Chronic Disease History Form

Please Email Or Fax This Form To Us Before Your Appointment.

You Must Save Your Form Before Emailing Or No Data Will Be Sent.

Name _____Date_____
Address _____ City_____ State_____Zip_____
Birthdate _____ Sex_____Marital Status_____ Home Phone_____
Work Phone_____ Email_____
How were you referred?_____
Occupation_____

General: **Please mark X on any conditions you have or have had:**

Digestion		Liver		Nose		Thyroid		Constipation	
Stomach		Lungs		Mouth		Spine		Diarrhea	
Colon		Heart		Esophagus		Rectum		Asthma	
Blood		Brain		Hair		Lymphatic		Allergies	
Muscle		Pancreas		Scalp		Circulation		Psoriasis	
Fat		Spleen		Skin		Fatigue		Eczema	
Bone		Gall Bladder		Immunity		Chronic Pain		Restless Leg	
Nervous Sys		Eyes		Infections		Joints		Concentration	
Reproductive		Ears		Colds		Insomnia		Emotions	

Your Condition: Briefly describe your condition.

When did this condition begin?_____

Is there a family history of this condition? _____

How severe are your symptoms? _____

How has the condition progressed since it began? _____

_____

Name and Phone number of current physician:

_____

Please list any medications or nutritional supplements you are taking:

Medication or Supplement	Purpose	Taking for How Long
1		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Please list any allergies you have to foods, drugs or other substances:

Substance	Reaction

What is your doctor's opinion about the prognosis of your condition? _____

How would you characterize the success or side effects of the treatments you have been receiving?

_____

Are you satisfied with your current medical treatment? _____

Please rate the overall intensity of your imbalances on a scale of 1 – 10. (1: mild, 5: moderate, 10: severe) _____

Is your sleep disturbed by the symptoms of your condition(s)? _____

To what extent are you having any degree of bodily pain or discomfort? _____

To what extent do your symptoms interfere with your daily activities?_____

How often are you having pain or discomfort? _____

How long does the pain or discomfort last on the average?_____

How would you rate your usual energy level compared to most people on a scale from 1 – 10 with 1 being very low energy, 5 average and 10 being very high energy? _____

Are you tired or rested when you wake up? _____

How well have you been able to cope with your regular activities and responsibilities? _____

_____

Please mark X on any conditions you have or have had:

Trembling		Nervousness	
Sleeplessness		Light Headedness	
Weight Loss		Intolerance to Cold Temperatures	
Intolerance		Excessive Perspiration	
Anger and Irritability		Burning Sensations in the Body	
Reddish Color of the Skin		Increased Frequency of the Bowel Mvts	
General Heaviness in the Body		Recurring Sore Throat/ Swollen Glands	
Skin Feels Cold to Touch		Lethargy	
Depression/Hopelessness		General Itching	

How often do you have bowel movements? _____

When do you usually have bowel movements? _____

Are the stools usually soft, medium, hard ? _____

Do you have any of the following urinary problems? _____

Have you ever taken frequent enemas or used laxatives in excess? _____

Sleep Is: (Mark X on any that apply)

Sound and of normal duration		Light & Interrupted	
Too little sleep		Too Heavy & Long	
Difficulty Falling Asleep		Difficulty Waking Up	
Awaken Too Early		Frequent Nightmares	

To what extent do you experience anxiety, worry, or nervousness? _____
_____

Do you work with computers or with chemicals or in a polluted environment? _____

Is your work environment polluted? _____

What is your body build? _____ Small Frame _____ Medium Frame _____Large Frame

What is your present state of mind and emotions? ☐ Excellent ☐ Good___ fair____ poor

What time do you fall asleep? _____

What time to you get up?_____

When do you eat Breakfast? _____

When do you eat Lunch? _____

When do you eat Dinner? _____

Do you skip or delay meals? _____

Do you have snacks between meals? _____

Do you travel a lot? _____

Do you sleep during the daytime? _____

How regular is your daily routine? _____

Do you often experience any of the following?
Worry_____ Fear or Panic _____ High Stress Level _____ Anxiety _____

Do you delay or suppress any of the following?

Bowel Mvts_____ Gas_____ Urination_____ Sleep_____ Vomiting_____
Yawning_____ Burping_____ Breathing_____ Hunger_____ Thirst_____

How often do you exercise?_____

Is your exercise: ___ Vigorous ___ moderate ___ light ___ don't exercise

Is your diet? ____ Vegetarian ____ non-vegetarian _____ mostly vegetarian

Do you smoke? _____

If so how many packs/day? _____

How often do you consume alcohol? _____

What type of weather makes you feel most uncomfortable:

Cold _____ Hot _____ Cool & Damp ____

Section for women only:

How regular is your menstrual period? _____

How many days does your menstrual period last? _____

How heavy is your menstrual flow? _____

Associated symptoms (before or during menstruation)
___ None ____ Pain ___Acne ____Tension ____ Fluid retention ____Depression ___Migraine

Do you have any discharge outside of your menstrual period? ___ no__ yes, color _____

Are you pregnant _____

Do you take contraceptive pills? _____

Number of previous pregnancies: _____