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___________________a
Address ____________________________ City_____________ State____ _Zip______a
Birthdate ____________ Sex_____Marital Status______ Home Phone________________
Work Phone_______________ Email____________________aaaaaaaaaaaaaaaaaaaaa
How were you referred?______________aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa
Occupation____________________________aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa

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 were you first diagnosed with this condition? ______________________________

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		
2		
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? ___________________________

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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: ____