



Chrysalis Health Solutions

The Butterfly Effect

Please complete all questions to the best of your ability. PLEASE PRINT.

Patient Name: _____ Date: ___/___/___ Age ___ DOB: ___/___/___

Gender: Male Female Marital Status: S M W D No. of Children & Ages _____

Height: _____ Weight: _____ Blood Type (If Known): _____

Email Address: _____ Home Address: _____

Home Phone: () _____ Work Phone: () _____ Fax: () _____

Emergency Contact (Name of relative or close friend not living with you):

Name: _____ Phone: () _____

Address: _____

Name/Address of current medical physician: _____

Whom can we thank for referring you: _____

What is the primary reason that you are seeking alternative health care? _____

Please list all current symptoms that you are experiencing: _____

Drugs you currently take (prescription/over the counter):

- Nerve Pills Pain Killers Muscle Relaxers "Pep" Pills Tranquilizers
 Birth Control Pills High Blood Pressure HRT Antidepressants Sleep Aids
 Others: _____

Do you take vitamins or minerals? _____ Yes _____ No
Please describe: _____

Do you think you may need vitamins or minerals? _____ Yes _____ No
Why? _____

Do you have an allergy to any drug/herb? _____ Yes _____ No
Please list: _____



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HABITS	Heavy	Moderate	Light	None	Frequency Per Day/Week
Alcohol	[]	[]	[]	[]	_____
Coffee/Soda	[]	[]	[]	[]	_____
Tobacco	[]	[]	[]	[]	_____
Drugs	[]	[]	[]	[]	_____
Exercise	[]	[]	[]	[]	_____
Sleep	[]	[]	[]	[]	_____
Appetite/Meals	[]	[]	[]	[]	_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

Abortion	Breast Lump	Head/Spine Injury	Miscarriage	Retinal Detachment
Abuse (Physical, Mental, Emotional)	Breast Cancer	Heart Disease	Multiple Sclerosis	Rheumatic Fever
AIDS/HIV	Bulimia	Herniated Disc	Mumps	Scarlet Fever
Alcoholism	Cancer	High Cholesterol	Osteoporosis	Stroke
Anemia	Diabetes	Influenza	Parkinson's Disease	Testicular Pain
Anorexia	Eczema	Lumbago	Pleurisy	Tuberculosis
Appendicitis	Emphysema	Malaria	PMS	Ulcers
Bleeding Disorders	Epilepsy	Mastectomy	Pneumonia	Vaccinations
Blood in Urine/Stool	Goiter	Measles	Polio	Venereal Disease
Burning/Painful Urination	Gout	Migraine Headaches	Prostate Problems	Other: _____ _____ _____

List past surgeries (include year) and illnesses: _____

Have you been in an auto accident: [] Past Year [] Past 5 Years [] Over 5 Years [] Never

Have you ever had any mental or emotional disorders? _____ Yes _____ No When? _____

Have any others in your family had such disorders? _____ Yes _____ No When? _____

Have you ever been knocked unconscious? _____ Yes _____ No When? _____

Used a cane, crutch, or other support device? _____ Yes _____ No When? _____

Been treated for a spine or nerve disorder? _____ Yes _____ No When? _____

Been treated for a spine or nerve disorder? _____ Yes _____ No When? _____

Fractured a bone? _____ Yes _____ No When? _____

Been hospitalized for anything other than a surgery? _____ Yes _____ No When? _____



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Date of Last:	Less than 6 months	6-18 months	Over 18 months	Never
Physical Exam	[]	[]	[]	[]
Spinal X-Ray	[]	[]	[]	[]
Blood Test	[]	[]	[]	[]
Urine Test	[]	[]	[]	[]
Spinal Exam	[]	[]	[]	[]
Chest X-Ray	[]	[]	[]	[]
Dental Exam	[]	[]	[]	[]
Mammogram *If applicable	[]	[]	[]	[]

Pregnancies (include date of pregnancy & outcome- vaginal vs. caesarian, difficulties) *If applicable only: _____

Please define job description & work schedule: _____

Describe lifestyle (hobbies, diet): _____

With specificity, write what it is you hope to achieve upon learning the results of the alternative testing: _____

Describe the steps you are willing to take to achieve any lifestyle changes or health goal(s): _____

List individuals who will be helpful and supportive to you during your quest for better health, naturally: _____