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:____

____

Sample

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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: __________ __________ __________

Sample

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: ______________

____

____

____

Sample