CFS History Record

(Chronic Fatigue Syndrome & Fibromyalgia)

Allow 30 minutes to complete this form

KARUNA HEALTH CARE
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Date.....

Name.....Age.....Sex.....DOB.....

Address.....Post Code.....

Phone: **H:**.....**W:** .....**Mob**.....

Email.....Health Fund.....

Occupation.....Marital Status:.....Children.....

GP's name, address and contact number: .....

Specialist's name, address and contact number: .....

* For distance consultations, please indicate how we are able to contact you:
□ Email □ Telephone □ Fax (.....)..... □ Skype (preferred method) **Your Skype Name**.....

Please complete the following pages in as much detail as you can. Providing detailed information makes it easier to accurately assess you - no detail is too small! Use extra pages (or the reverse side) if needed.

List your symptoms, in order of severity. (First symptom the most severe)

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How and when did your symptoms start?

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Do you have any other health problems? If yes, please list:

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What medical treatment(s) have you had so far?

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What natural therapies have you used so far?

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Which of these treatments have you found to be the most effective?

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Please list your current supplements – vitamins, minerals etc

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Please list all your **current** prescribed medications

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General health & lifestyle information.

Please rate your energy levels (circle) [No energy] **0 1 2 3 4 5 6 7 8 9 10** [high energy]

Symptoms during sleep? *Please circle:*

Snoring, mouth breathing restlessness, sleepwalking, night sweats, perspiration, nightmares

Any other symptoms during sleep? ……

Regular wakefulness? ……Time of waking? …… Reason for waking? ……

What position do you like to sleep in? .....

How do you feel in the morning after waking?…….,……

Any amalgams? (silver fillings) ……

Do you have any drug, environmental, food, or other allergies? Please state…….

……

How do you tolerate hot weather?……..…Cold weather?……..…

Does any type of weather affect your symptoms? Please describe……

Which season do you feel: most comfortable in?.....

How much alcohol do you drink? ……What type? ……..…….……

What type of exercise do you do? …… How often?……..…….

Digestion:
Do you suffer: □ Pain □ Bloating □ Indigestion □ Burping □ Diarrhoea □ Constipation □ Wind

When do you get these symptoms in relation to eating? Before, during or afterwards?

……

……

What are your favourite foods? ……

Do you have any food cravings? If so, what are they and the time of day that you most crave them?

……..

List any foods that you really dislike……

List any foods that disagree with you, *even if you like them*…… ……..…..…..……..

Mental/Emotional

Do you have any fears or phobias? (eg heights, spiders, tunnels, crowds, snakes, the dark, public speaking, thunderstorms)

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If anxious, what do you worry about?

……

Is there anything about yourself, apart from your presenting complaint, which you feel impedes your ability to enjoy life and which you would like to change?

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……

Family History
Please describe **all known diseases** of the following family members; eg heart disease; high blood pressure; diabetes; cancer; skin problems (eg psoriasis); TB; allergies; mental illness; alcoholism

Mother ……

Father ……

Immediate family (brothers, sisters, grandparents, aunts and uncles;

……

……

Please list the medical tests that you have had:

TYPE OF TEST	DATE	REASON	RESULT
□ Blood test(s)			
□ X Ray(s)			
□ CT scan			
□ Ultrasound			
□ Hearing test			
□ Other			

Anything else you would like to mention?

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……

Where did you hear about this clinic?

☐ Word of Mouth ☐ Advertisement ☐ Brochure ☐ Yellow pages book ☐ Yellow Pages online
☐ Natural Therapy Pages ☐ Personal Internet search ☐ Other ……

BEFORE COMING TO CLINIC:

- To help our chemically sensitive patients, please **do not wear perfume or aftershave** when attending the clinic.
- If you would like to know the amount of your Health Fund rebate, please check with your fund prior to your consultation.

YOUR HEALTH TIME LINE *(the order that your illnesses occurred)*

An accurate time line of health and other events is extremely important. Include factors that have had a significant impact on your nervous system: stressful events, injuries, surgeries, hospitalisations, vaccinations and medications taken and any side effects noted, viruses, infections, allergic reactions. Use an extra sheet if you need more space.

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