Amy Lane
LMSW

Complete before consultation and bring to appointment

MANAGING CHRONIC DISEASE

Name _____

Address _____

Home Phone _____ Can I leave a message: YES NO Preference_____

Cell Phone _____ Can I leave a message: YES NO Preference_____

Work Phone _____ Can I leave a message: YES NO Preference_____

Email _____

DOB _____

Condition _____ Year of medical diagnosis _____

Family members with same illness _____

Current medications (including OTC and herbal supplements (feel free to attach a separate sheet)_____

_____

Year and dates of any surgeries and type _____

Year and dates of non-surgical hospitalizations _____

Emergency contact _____

What is your current support system? _____

Do you have any dietary restrictions? _____

Do you keep a food journal? _____

How do you cope with stress? _____

How many hours of sleep do you get each evening? _____

Do you exercise? (If so please list type of activity and duration) _____

Do you smoke? If so how much? _____

Do you drink? If so how many drinks per week? _____

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