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| --- | --- |
| **Name :** |  |
| **Age :** |  |
| **Height :** |  |
| **Weight :** |  |
| **Sex :** |  |
| **Disease Name :** |  |
| **Your Medical History before and after the onset of your health challenge?** |  |
| **Any other Health Complications due to existing illness or any other past illnesses?** |  |
| **Please describe your Daily Routine?****Example:****1. What time you get up? What do you do first?** **2. What do you do during your day?** **3. How many times do you eliminate in a day?** **4. What is your Daily Food Intake?** **5. What time do you take your meals?** **6. Do you eat slowly?** **7. Chew your food completely? Etc.** |  |
| **How long have you been suffering from your current health challenge?** |  |
| **Please list any and all health issues you may be experiencing now or in the past?** |  |
| **Other Symptoms or Problems including any emotional issues?** |  |
| **Where do you live, and how are you affected by the climate of your area?** |  |
| **Email Address :** |  |
| **Alternative Email :** |  |
| **Contact No :** |  |