Health Examination Form

1. Name .....Gender.....Age.....

2. Date of Birth...../...../..... Place of Birth.....

3. Address:-

Residential .....

.....

Official .....

.....

4. Telephone No. ..... Mobile No. .....

E-mail.....

5. Working Hours..... Job Type.....

Living Condition Open / Polluted / Having Proper Air & Sunlight

Residence / Family :

Working Place :

6. Family Circumstance : Tense / Good Harmony / General

7. Financial : Self Sufficient or Dependent

8. Nature / Attitude : Anger / Calm Fast / Slow Joy / Sorrow Fear / Fearless

: Tension / Free mind Positive / Negative Patient / Impatient

9. Reasons for Tension : Family / Occupation-Professional / Social / Financial

10. Timing

Morning awaking Time :

Sleeping time at Night :

11. Meal : (Breakfast) (Lunch) (Dinner)

12. Appetite : Normal / less / More Vegetarian / Non-Vegetarian

13. How many times you generally take eatable / drink daily?

14. Do you observe partly or complete fast? Yes / No Weekly / Fortnightly / Monthly

15. Specific Drinking Habit : Cold / Hot / Too Cold / Too Hot

16. Drinking habit of water : 1. Morning Empty Stomach

: 2. Before Meal

: 3. During Meal

: 4. How much time after meal

17. Whether you do any exercise, Pranayam, Swadhyaya, Prayer, Meditation or any other activity for body, Mind & Spiritual Purification (Give details)

18. Brief description of previous history of diseases:-

Since Birth Accidental / Surgery Heredity Side effect of Treatment

19. When disease was noticed first?

20. Current Health Status : Height..... Weight.....

21. Treatment done so far :

22. If any of the following body part is abnormal explain with detail comments:-

Respiratory Trouble Skeletal Problem Digestive Problem Neurological

Cardio Vascular Skin Muscles Urinary

Spinal Problem Swelling Eyes / Ears / Nose / Throat / Teeth / Mouth

23. Stool : Constipation / Solid / Loose / Regular / Irregular

24. Stool releasing time : Immediate / Normal / Time Taken

25. Urine releasing time : No. of Times

1. In Day 2. In Night

26. Latest Testing Report :

27. Which books you have read written by Dr. Chordia?

28. Have you visited our website? : www.chordiahealthzone.com

29. Select the following facts about maximum or minimum interest or unpleasant associated with you:

Colour : Green Red yellow White Black / Blue

Taste : Sour Bitter Sweet Pungent Salty

Smell : Musk Brunt Sweet fragrance Fishy Stale

Sound : Loud Laughter Singing Melody Singing Morning

Emotions : Anger Joyful Agony obsession Sadness Fear

Sense : Sight Speech Taste Smell Hearing

Body Fluid

Secretion : Tears Sweat Saliva Mucous Urine

Season : Spring Summer Rainy Change of Season Autumn Winter

30. Time of maximum comfort:

31. Time of maximum discomfort / during day/ Night:

32. Have you been treated by Acupressure Previously, if yes, then state how many times.

33. Reflex points of maximum pain at both side of sole and palm felt by you

34. Can you drink your own Urine?

35. Do you know about changing nasal swar (Surya & Chandra) at any time?

36. Who suggested you to contact us?