Access to Health Chiropractic Center

598 West Main Street Norwich, CT 06360
(860)889-1475

Signature on File

PLEASE READ AND INITIAL EACH LINE

____ I authorize use of this form on ALL of my insurance submissions
____ I authorize release of information to all of my insurance companies
____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies and authorize payment directly to my doctor.
____ I authorize Access to Health to obtain medical information from other medical professionals including test results.
____ I permit a copy of this authorization be used in place of the original.

_____ _____

Patient Name (Printed) Patient Signature or Parent/Guardian

598 West Main St, Suite 1 Norwich, CT 06360

Access to Health Chiropractic Center Phone (860) 889-1475 Fax (860) 889-2850

Please fill out the following as thoroughly as possible. Print clearly and mark anything you don't understand with a question mark. This questionnaire asks about your physical, mental and emotional health, all of this information will then assist the doctor in providing you with the best naturopathic care possible.

Personal Information

Today's Date_____

Name_____ Age _____ Date of Birth ____/____/____ Sex M / F

Address _____ City_____ State_____ Zip_____

Social Security #____-____-_____ Phone Number (___)____-_____ Secondary Phone (___)____-_____

Parent/Guardian Name _____ Relationship_____

Emergency Contact Name/Relation _____ Phone Number (___)____-____

When was medical care last received? _____

Where? _____ Why? _____

Doctor(s) currently seen:

Name_____ Practice Name _____

Address _____ City_____ State_____ Zip_____

Office Phone (___) _____ Office Fax (___) _____

Name_____ Practice Name _____

Address _____ City_____ State_____ Zip_____

Office Phone (___) _____ Office Fax (___) _____

Vaccinations/ Immunization

Y N Polio	Y N Pertussis	Y N Chicken Pox
Y N Tetanus	Y N Diphtheria	Y N MMR (measles/mumps/rubella)
Y N Hepatitis B	Other_____	

Childhood Illnesses-

Y N Rubella	Y N Measles	Y N Roseola
Y N Mumps	Y N Chicken Pox	Y N Whooping cough
Y N Polio	Y N Eczema	Y N Rheumatic Fever
Y N Diphtheria	Y N Asthma	Y N Scarlet Fever

Other_____

List any known allergies (environmental, food, drug) and reaction: _____

_____

_____

Do you currently take any of the following medications? Check all that apply:

__Aspirin	__Ibuprofen or acetaminophen	__Sleeping pills	__Medicine to stay awake
__Laxatives	__Appetite depressants	__Antacid	__Antihistamine
__Cortisone	__Birth control pills/patch/ring	__Antibiotics	__Hormone/thyroid med

List all medications (prescriptions), vitamins, and other supplements currently taken or have taken in the past year. Attach additional sheet if needed.

Medication	Dosage/Frequency	Dates	Reason for Taking	Who Prescribed

If any of the following apply, please fill in known information, add other procedures if needed:

Procedure	Reason	Date	Outcome	Procedure	Reason	Date	Outcome
Hospitalization				Hospitalization			
Surgery				Surgery			
X-Ray				MRI			
Other:				Other:			

Current Health History-

Please check next to appropriate item(s), or circle as indicated:

Head- eyes, ear, nose, throat

Now	Past		Now	Past		Now	Past	
___	___	headaches	___	___	dizziness	___	___	runny nose
___	___	blurry vision	___	___	fainting/blackouts	___	___	loss of smell
___	___	halo around objects	___	___	loss of balance	___	___	nosebleeds
___	___	eye pain/red eye	___	___	ringing in ears	___	___	neck lumps
___	___	loss of vision	___	___	difficulty hearing	___	___	earaches
___	___	grinding teeth	___	___	cold/canker sores	___	___	sore throat
___	___	dental problems	___	___	difficulty swallowing	___	___	hoarse voice

Chest- lungs, heart

Now	Past		Now	Past		Now	Past	
___	___	wheezing	___	___	chest colds	___	___	palpitations
___	___	shortness of breath	___	___	unexplained fever	___	___	chest pain
___	___	cough up blood	___	___	night sweats	___	___	swollen feet
___	___	cough up phlegm	___	___	rapid/skipped beats	___	___	high blood pressure

Abdomen- stomach, liver

Now	Past		Now	Past		Now	Past	
___	___	indigestion	___	___	pain in abdomen	___	___	constipation
___	___	light colored stool	___	___	nausea	___	___	diarrhea
___	___	rectal pain or itch	___	___	loss of appetite	___	___	vomiting
___	___	frequent belching/gas	___	___	yellow skin/jaundice	___	___	excessive appetite

Genitourinary- reproductive organs, bladder

Now	Past		Now	Past		Now	Past	
___	___	frequent urination	___	___	pain w/urination	___	___	blood in urine
___	___	urge to urinate	___	___	weak urine stream	___	___	kidney stones
___	___	incontinence	___	___	groin itching	___	___	rash/itching

Musculoskeletal- joints, bones

Now	Past		Now	Past		Now	Past	
___	___	sore/swollen joints	___	___	leg cramps	___	___	restless legs
___	___	aching muscles	___	___	weakness	___	___	broken bones
___	___	numbness	___	___	tingling	___	___	hives
___	___	rash/itching	___	___	bruising	___	___	acne

Nervous system and Mental Emotional

Now	Past		Now	Past		Now	Past	
___	___	anxiety	___	___	loss of memory	___	___	nervousness
___	___	ADD/ADHD	___	___	lonely	___	___	depressed
___	___	hopelessness	___	___	frequent crying	___	___	frequent worry
___	___	difficulty relaxing	___	___	shy/sensitive	___	___	angered easily

___ ___ work problems ___ ___ family problems ___ ___ suicidal
___ ___ difficulty with decisions ___ ___ scary thoughts/dreams ___ ___ annoyed by little things

Men only

Now	Past		Now	Past		Now	Past	
___	___	painful testes	___	___	swelling in testes	___	___	discharge
___	___	impaired fertility	___	___	prostate problem	___	___	sexual abuse
___	___	self-testicular exam	___	___	sexually active	___	___	condom use

Sexual orientation: Heterosexual___ Homosexual ___ Bisexual___ Transgendered ___

Women only

Now	Past		Now	Past		Now	Past	
___	___	missed period(s)	___	___	irregular bleeding	___	___	chronic yeast
___	___	frequent vaginitis	___	___	breast pain/lump	___	___	PMS
___	___	PCOS	___	___	endometriosis	___	___	sexual abuse
___	___	vaginal dryness	___	___	HRT	___	___	hot flashes
___	___	genital irritation	___	___	vaginal discharge	___	___	infertility
___	___	difficulty w/exams	___	___	heavy/light menses	___	___	nipple discharge
___	___	sexually active	___	___	bearing down feelings	___	___	facial hair/hair loss
___	___	painful intercourse	___	___	irregular bleeding	___	___	chronic yeast

Sexual orientation: Heterosexual___ Homosexual ___ Bisexual___ Transgendered ___

Number of pregnancies ____ live births ____ miscarriages ____ abortions____
Age of first menses ____ Do you perform self breast exams? Y / N Date of last pap ___/___/___
Usual length of cycle (from first day of bleeding to next) period ___ Date of last menses ___/___/___
Do you use birth control? (List all types used) _____
List any other health issues/symptoms: _____
_____
_____
_____

Family History

If you or anyone in your immediate family has or had any of the following conditions, please indicate who was affected (self, mother, father, sibling):

Cancer (type) _____ Diabetes_____
Anemia_____ Arthritis_____
Heart Disease_____ Asthma/hay fever/hives _____
Stroke_____ Osteoporosis_____
High Blood Pressure_____ Depression_____
Alcoholism or substance abuse_____ Autoimmune Disease_____
Attempted suicide_____ Kidney disease_____
Mental illness_____ Seizures/ Epilepsy_____

Glaucoma_____ Gout_____

Other_____ Other_____

Prenatal/Birth/Feeding History_____

1. Mother's health during pregnancy for this child (check/describe)

Age _____ Trauma/Injury_____ Alcohol ____drinks per day

Caffeine _____ cups per day Bleeding_____ Stress_____

Drug use_____ Nausea _____ High Blood Pressure_____

Smoking_____ per day Illness_____ X-Rays_____

Toxemia_____ Medications_____ Other_____

2. Term

   _____ Full ____ Premature (weeks/months?) ____Late ____Birth Weight

3. How was pregnancy? ____ Easy ____ Difficult

   Explain _____

4. Place of birth? ____Hospital ____Home ____Clinic _____Other

5. Interventions at labor/birth

   ____ Pitocin ____Epidural ____Demerol/other pain med

   ____Forceps ____C-section ____Vacuum extraction

6. Feeding

   ____ Breast fed? _____ How long? ____ Cow's Milk?

   ____ Formula fed? _____ How long? _____ Type of formula

   ____ Age solid food begun What foods first introduced? _____

   Any food sensitivities seen? _____

   Favorite foods? _____

7. Sample daily diet (choose typical day and include food and liquids)

   _____

   _____

   _____

   _____

Social History_____

Parents: ____ Married ____ Partnership ____Separated ____ Single ____ Divorced

Parent's occupation _____ Full/Part time? _____

Parent's occupation _____ Full/Part time? _____

Other guardian? _____ Relationship? _____

Others residing in home/Relationship_____

Daycare/Pre-School/School _____ Where?_____

Hours per day? _____ Days of the week: M T W TH F

Siblings (Name, age, any health concerns?)

_____

_____

_____

Have you traveled outside the U.S. in the past 5 years? Where? _____

Do you camp? _____ Where? _____

Exercise _____ hours/week What types? _____

Hobbies? _____

Does he/she take time to relax? Y / N How? _____ Number of hours watched TV____/day

Religious/spiritual belief? Y / N Do you practice regularly? _____

Major life changes in the last year_____

Level of stress __low__ medium__ high How do you handle stress? _____

Diet

Circle # of meals eaten per day: 1 2 3 more than 3

Commonly eaten foods in your day to day diet _____

_____

Food excluded from your diet _____

Caffeinated drinks (coffee, tea, soda) _____/day

Foods/drinks that you crave: _____

Are you thirsty? _____ Preferred temperature of drinks: _____

Sleep

Hours/night _____ Is this enough? Y / N Do you have any problems with your sleep? _____

Any recurring dreams? _____

Any position that you always sleep in? Or cannot sleep in? _____

Environmental Exposures

Circle any of the following that you are exposed to:

gas heat oil heat wood stove electric heat air conditioning tap water dust mold excessive dampness/dryness animal / pet hair poor ventilation amalgam fillings

List any other exposures:_____

_____

Outdoor work (what type) _____

Indoor work (what type) _____

List chemicals/odors/dust you are exposed to at work currently or have been in the past (eg: toner ink, bark, dust, flour dust, hair color…) _____

_____

Hobbies or Activities

List any chemical/odors/dust you are exposed to from hobbies or have been in the past: _____

_____

Write any additional concerns or anything you'd like to include to help us get to know you better: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____