Dr. Kathleen Cannon, Naturopathic Physician

Access to Health Chiropractic Center

57 Lafayette Street
Norwich, CT 06360

New Patient Intake Form + Health Questionnaire (Male)

Contact Information

First Name:	Middle Name:	Last Name:
Preferred Name:	Gender: Age:	Date of Birth:
Phone 1:	Voicemail consent: Y / N	
Phone 2:	Voicemail consent: Y / N	
Email:	Email Consent: Y / N *(email is not a secure communication)*	
Street Address:		
City/Town:	State:	Zip:

Work Information

Occupation:	Employer:
Work Address:	

Emergency Contact

Name:	Relationship to you:
Phone 1:	Phone 2:

Other Healthcare Providers

Primary care doctor:	Phone:

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Please list any other doctors you see.

Name:	Specialty:	Phone:
Name:	Specialty:	Phone:
Name:	Specialty:	Phone:
Name:	Specialty:	Phone:
Name:	Specialty:	Phone:

Other Information

Have you seen a naturopathic doctor before? Y / N
If yes, who did you see?
Please describe your experience:
What are you most interested in at our clinic?
How did you hear about us?
Who may we thank for recommending us, if applicable?

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Dr. Cannon is committed to providing exceptional care for you.
To optimize your healthcare, it is important that we have a full understanding of you as a whole person - body, mind, and spirit.

Please take your time to complete this questionnaire thoroughly and thoughtfully - this is for you.
If you are uncomfortable answering any questions, you may leave those blank to be further discussed during your appointment.

What is your reason for seeking naturopathic care?

What are your top three priorities for your first visit?

What are your longer term health goals?

How motivated are you to make changes to your lifestyle that will support your health? (0 is no motivation, 10 is 100% motivation)

0 1 2 3 4 5 6 7 8 9 10

What potential obstacles do you see in making healthy changes and following any recommendations we may provide?

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Health Concerns: please list in order of importance:

Describe your main concern (symptoms, impact on your life, etc.):

When did your main concern begin? _____

Have you received medical care for this? Y / N

If yes, please describe:

Are you currently receiving care or treating this? Y / N

If yes, please describe:

Have you treated this with anything outside of medical care? Y / N

If yes, please describe:

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Medical History

Please list any current medical diagnoses:

Diagnosis	When diagnosed	Medication/treatment and effect on you

List any past hospitalizations, surgeries or traumas throughout your life, including dates:

List any major illnesses throughout your life, including dates:

List any recurrent illnesses:

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List any health issues you had as a child (physical, mental and emotional):

Allergies:

Any allergies to foods? Y / N

Any allergies to environment, including seasonally? Y / N

Any allergies to medications? Y / N

If yes to any allergies above, please describe what you are allergic to and your reaction:

Please indicate if you have ever had any of the following conditions:

	Abscesses		Asthma		Cancer		Chicken pox		Diabetes
	Emphysema		Epilepsy		Gallstones		Goiter		Heart disease
	Hepatitis		Kidney disease		Malaria		Measles		Mononucleosis
	Mumps		Parasites		Peritonitis		Pleurisy		Pneumonia
	Prostatitis		Rheumatic fever		Sepsis		Skin problems		Stroke
	Tonsillitis		Tuberculosis		Typhoid		Warts		Worms

Other: _____

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Medications

List all prescriptions and over-the-counter medications you are taking, including pain relievers, laxatives, antacids, and sleeping aids. Also include any herbal, homeopathic, hormonal, and nutritional (vitamins/minerals) supplements.

Medication, Supplement, etc.	Reason	Dosage	Date Began	Effective (Y/N)

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Imaging/Diagnostic Studies:
Have you had any of the following studies? Please list below, starting with the most recent.
X-Ray, Ultrasound, CT Scan, MRI, Mammogram, DEXA scan, EKG, EEG, Colonoscopy, Other

Imaging	Date	Result

Were you vaccinated as a child? Y / N

Please describe any reactions to immunizations (include vaccine and age):

_____

_____

_____

What is your blood type? (If unknown, leave blank.) _____

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Describe a typical day of food (with honesty and no judgement - include everything you typically eat).

Breakfast: Time: _____

Lunch: Time: _____

Dinner: Time: _____

Snacks: Time(s): _____

Desserts: Time(s): _____

Beverages (type and amount - example: (2) 8-ounce glasses of water, 1 can diet coke, etc.):

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Please describe your daily routine in general (most days), briefly, including each activity and how long you spend (for example: watching TV from 6-8pm):

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Review of Systems **C = current; P = past; N = never (please circle one)**

General					**Nose and Sinus**			
Weight loss or gain	C	P	N		Loss or change in smell	C	P	N
Night sweats	C	P	N		Sinus infection or pain	C	P	N
Fever	C	P	N		Hayfever or allergies	C	P	N
Chills	C	P	N		Nasal polyp	C	P	N
Head					Nose bleeds	C	P	N
Frequent Headaches	C	P	N		**Mouth and Throat**			
Migraines	C	P	N		Frequent sore throat	C	P	N
TMJ, jaw pain or clicking	C	P	N		Teeth grinding	C	P	N
Head injury	C	P	N		Bleeding gums	C	P	N
Eyes					Dental fillings	C	P	N
Eye injury	C	P	N		Bad taste in mouth	C	P	N
Blurry vision	C	P	N		Difficulty swallowing	C	P	N
Double vision	C	P	N		**Neck**			
Vision loss or impairment	C	P	N		Swollen gland	C	P	N
Excess tears / watery eyes	C	P	N		Goiter	C	P	N
Dry eyes	C	P	N		Pain or stiffness	C	P	N
Eye infection	C	P	N		Neck injury	C	P	N
Glaucoma	C	P	N		**Respiratory and Chest**			
Cataracts	C	P	N		Frequent cough	C	P	N
Glasses or contacts	C	P	N		Asthma	C	P	N
Ears					Chest or breathing pain	C	P	N
Ear infection	C	P	N		Spitting up blood	C	P	N
Change in hearing	C	P	N		Shortness of breath	C	P	N
Tinnitus / ringing in ears	C	P	N		Wheezing	C	P	N
Ear pain	C	P	N		Phlegm	C	P	N

Difficulty breathing	C	P	N	Yellowing skin or eyes	C	P	N
Emphysema	C	P	N	Liver disease	C	P	N
Tuberculosis	C	P	N	Heartburn, reflux, GERD	C	P	N
Pneumonia	C	P	N	Change in appetite	C	P	N
Bronchitis	C	P	N	Gallbladder disease	C	P	N
Cardiovascular				Pancreatitis	C	P	N
Chest pain or tightness	C	P	N	Ulcer	C	P	N
Heart attack	C	P	N	Average number of bowel movements/day: _____			
High blood pressure	C	P	N	Change in bowel habits	C	P	N
Low blood pressure	C	P	N	Constipation	C	P	N
High cholesterol	C	P	N	Diarrhea	C	P	N
High triglycerides	C	P	N	Bloody or black stool	C	P	N
Palpitations, fluttering	C	P	N	Hemorrhoids	C	P	N
Rheumatic fever	C	P	N	**Urinary**			
Heart murmur	C	P	N	Pain with urination	C	P	N
Blood clots	C	P	N	Increased frequency	C	P	N
Heart valve disease	C	P	N	Incontinence/leakage	C	P	N
Fainting	C	P	N	Waking at night to urinate	C	P	N
Ankle swelling	C	P	N	Blood in urine	C	P	N
Gastrointestinal				Foul-smelling urine	C	P	N
Nausea	C	P	N	Urinary tract infection	C	P	N
Vomiting	C	P	N	**Skin**			
Blood in vomit	C	P	N	Rashes	C	P	N
Abdominal pain or cramps	C	P	N	Acne, boils	C	P	N
Belching	C	P	N	Eczema	C	P	N
Passing gas/flatulence	C	P	N	Psoriasis	C	P	N

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Hives	C	P	N	Muscle spasms or cramps	C	P	N
Change in moles	C	P	N	Arthritis	C	P	N
Dry skin	C	P	N	Weakness	C	P	N
Itchy skin	C	P	N	Sciatica	C	P	N
Excessive sweating	C	P	N	Low back pain	C	P	N
Oily skin	C	P	N	**Neurological**			
Sores that will not heal	C	P	N	Seizures	C	P	N
Nails				Loss of memory	C	P	N
Brittle nails (break easily)	C	P	N	Dizziness	C	P	N
Discoloration	C	P	N	Numbness or tingling	C	P	N
Pitting	C	P	N	Loss of balance	C	P	N
Fungus	C	P	N	Paralysis	C	P	N
Endocrine				Easily stressed	C	P	N
Hair loss	C	P	N	**Vascular**			
Brittle hair, split ends	C	P	N	Easy bleeding, bruising	C	P	N
Excessive thirst	C	P	N	Deep leg pain	C	P	N
Fatigue	C	P	N	Varicose veins	C	P	N
Intolerance to heat or cold	C	P	N	Anemia	C	P	N
Excessive hunger	C	P	N	Cold hands or feet	C	P	N
Hypothyroid	C	P	N	Thrombophlebitis	C	P	N
Hyperthyroid	C	P	N	**Immune**			
Low blood sugar	C	P	N	Chronic infections	C	P	N
Autoimmune disease	C	P	N	Chronic swollen glands	C	P	N
Musculoskeletal							
Joint pain or stiffness	C	P	N				
Broken bones	C	P	N				

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Male Systems

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Hernia	C	P	N	Difficulty urinating	C	P N
Testicular pain	C	P	N	Decreased force of urine	C	P N
Testicular masses	C	P	N	Prostate issues	C	P N
Morning erections	C	P	N	Penile discharge	C	P NN
Impotence	C	P	N	Sores/lesion on genitals	C	P N
Premature ejaculation	C	P	N	Testicular cancer	C	P N
Libido changes	C	P	N	Vasectomy	Y	N
STDs / STIs	C	P	N	Date of last prostate exam:		
If yes above, which:				Sexual desire (0-10; 0 = none):		

Any other conditions:

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Family History

Please indicate if anyone in your extended family has had any of the following:

	Asthma		Anemia		Arthritis		Alzheimer's		Depression
	Diabetes Type 1		Diabetes Type 2		Heart disease		Hypertension		Kidney disease
	Lung disease		Mental illness		Obesity		Osteoporosis		Parkinson's
	Stroke		Thyroid disease						
	Addiction and to what:								
	Autoimmune disease and type(s):								
	Cancer and type(s):								

Other:

What is your ethnicity and/or heritage (as much as known)?

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Please fill in the information below to the best of your knowledge and as applicable.

Relation	**Medical Conditions**	**Age if living**	**Age at death**	**Cause of death**
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling:				
Sibling:				
Sibling:				
Child:				
Child:				
Child:				
Other:				
Other:				

If there is anything else you would like to mention at this time, please share below.

Thank you for taking the time and energy to complete this form fully.
The information you provide will help us to provide the best naturopathic care for your individual needs.
We look forward to seeing you soon.