Dr. Kathleen Cannon, Naturopathic Physician
Access to Health Chiropractic Center
57 Lafayette Street
Norwich, CT 06360

New Patient Intake Form + Health Questionnaire (Female)

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:
OB/GYN (females):	Phone:

Please list any other doctors you see.

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

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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.

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 or other treatments for this? 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:

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 + Supplements

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.) _______________

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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Review of Systems **C = current; P = past; N = never**

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

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			

Female Systems

Age of first menses: ____________

Age of last menses (if applicable): ____________

Duration of menses (blood flow), on average: ____________ days

Length between cycles, average (length from start of menses to start of next menses): ____________ days

Number of pregnancies: ____________

Number of miscarriages: ____________

Number of live births: ____________

Number of abortions: ____________

Female Systems: **C = current; P = past; N = never**

Painful menses	☐ C ☐ P ☐ N		Breast lumps	☐ C ☐ P ☐ N
Heavy or excessive flow	☐ C ☐ P ☐ N		Breast pain or tenderness	☐ C ☐ P ☐ N
Irregular cycles	☐ C ☐ P ☐ N		Nipple discharge	☐ C ☐ P ☐ N
Bleeding between cycles	☐ C ☐ P ☐ N		Discoloration of skin	☐ C ☐ P ☐ N
PMS symptoms	☐ C ☐ P ☐ N		Breastfeeding	☐ C ☐ P ☐ N
Pain during intercourse	☐ C ☐ P ☐ N		Breast implants	☐ C ☐ P ☐ N
Ovarian cysts	☐ C ☐ P ☐ N		Breast self exams?	☐ Y ☐ N
Infertility	☐ C ☐ P ☐ N		Date of last mammogram:	
Difficulty conceiving	☐ C ☐ P ☐ N		Birth control pills	☐ C ☐ P ☐ N
Vaginal discharge	☐ C ☐ P ☐ N		IUD	☐ C ☐ P ☐ N
Vaginal dryness	☐ C ☐ P ☐ N		Other contraception:	
Vaginal odor	☐ C ☐ P ☐ N		Hysterectomy	☐ Y ☐ N
Vaginal yeast infection	☐ C ☐ P ☐ N			
Vaginal bacterial infection	☐ C ☐ P ☐ N		Libido changes	☐ C ☐ P ☐ N
STDs / STIs	☐ C ☐ P ☐ N		Sexual desire (0-10; 0 = none):	
If yes above, which:				

Any other conditions:

___

___

___

Date of last Pap: ____________

What was the result? ____

Have you ever had an abnormal Pap? Y / N

If yes, when and what was the result? ____

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Family History

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.
We look forward to seeing you soon.