

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: <i>communication</i>		Email Consent: Y / N (<i>email is not a secure</i>
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:

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

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?

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

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:

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

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:

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

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:

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

Other: _____

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

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.) _____

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

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.):

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

Review of Systems

C = current; P = past; N = never

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

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

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

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

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

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

Male Systems

C = current; P = past; N = never

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

Any other conditions:

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

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.