Dr. Caitlin O'Connor
All Families Natural Health
2530 West 29th Ave
Denver, Colorado 80211
720-855-3160
drcaitlin@allfamiliesnaturalhealth.com

All information on this form is confidential. If you are uncomfortable answering any questions, you may leave them blank and discuss them with your doctor

ADULT INTAKE

Name: ________________________________ Date: _______

Address: ____

City: ______________________State: ___________

Zip:__________________

Telephone (home): ________________________
(work): __________________________
(cell): __________________________
Can we leave a message? Y N
Email address:
____

Age: _______ Date of Birth: _______________________

Gender: Female / Male

Education:
____
Married:____ Separated:____ Divorced:____ Widowed:____ Single:____
Partnership:_____

Live with: Spouse:____ Partner:____ Parents:____ Children:____
Friends:____ Alone:____

Occupation: ____
Hours per week: ________
Do you enjoy your work: _________

How did you hear about this clinic?
____

If internet which site? ________________________________
Has any other family member already been a patient at this clinic?
____

Emergency contact: _______________________________
Relationship: __________________
Phone: ______________________
Address: ____
____

Successful health care is only possible when the doctor works towards a complete understanding of the patient physical, mental, and emotional well-being. Answering the following questions will help me create recommendations that are effective and appropriate. I appreciate your time, thoughtfulness and honesty in completing this overview.

Why did you choose to come to this clinic?

What do you know about our approach?

What three expectations do you have from this visit to our clinic?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and ability to implement our health

recommendations?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

Are you currently receiving healthcare? Yes / No
If yes, please list providers

____
____
____
____
____

If no, when and where did you last receive medical or health care?
____

What was the reason?
____

What are your most important health problems? List as many as you can in order of importance.
1) ____
2) ____
3) ____
4) ____
5)

FAMILY HISTORY
Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness

Asthma Hay fever Hives

Any other relevant family history? ______________________________

____

What is your family heritage?

____

Mother (age or age of death):
General Health: Poor Average Good Excellent

Father (age or age of death):
General Health: Poor Average Good Excellent

Siblings (age or age of death): Gender:
General Health: Poor Average Good Excellent

Siblings (age or age of death): Gender:
General Health: Poor Average Good Excellent

Siblings (age or age of death): Gender:
General Health: Poor Average Good Excellent

CHILDHOOD ILLNESSES
Please circle whether you had any of the following as a child:

Rheumatic fever Diptheria Scarlet fever Chicken pox
German Measles Measles Mumps

VACCINATIONS
Were you fully vaccinated as a child Y N
If no, which vaccines have you received?

Date of last Tetanus booster:
Do you receive seasonal flu vaccines Y N

HOSPITALIZATIONS/SURGERY/IMAGING
What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?
_____________________________ year _________
_____________________________ year _________
_____________________________ year _________
_____________________________ year _________

______________________________ year ________
____________________________ year ________

Any history of abnormal blood tests Y N
If so when and what test:

Have you had blood tests in last 5 years?

ALLERGIES
Are you hypersensitive or allergic to:

Drugs? What type of reaction?
____

Any foods? What type of reaction?
____

Any environmentals or chemicals? What type of reaction?
____

CURRENT MEDICATIONS
Do you take or use any of the following (please circle):

Laxatives Pain relievers Antacids Cortisone
Antibiotics Tranquilizers Sleeping Pills Thyroid Medication
Birth Control Pills Hormone Replacement Anti-Depressants

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

What you are taking	Why	Dosage	Does it help

GENERAL
Height: ____________________ Weight: _______ Weight one year ago: ___________

Maximum Weight: __________________________ When: ____________________

When during the day is your energy the best? ______ Worst? __________
Main interests and hobbies:
____
Exercise: Y N If so, what kind and how often:
____

Watch TV: Y N If so, how many hours? ________ Read: Y N If so, how many hours? _________ Computer: Y / N If so, how many hours? ________

Do you have a religious or spiritual practice? Y N

If so, what kind? ____________________________
Would you like to include aspects of your religion/spirituality into your health care?
Y N Maybe

Is your home a safe place (physically and emotionally)? Y N
Please explain:

Have you ever been touched in a way that made you uncomfortable or was harmful to you without your permission? Y N

Have you ever been physically or emotionally abused? Y N

Do you have concerns with abuse or violence in your life now? Y N

NUTRITION

Do you follow a specific diet (vegetarian, vegan, gluten-free, etc.) Y N
Please describe:

What percentage of your meals do you eat out? 10% 25% 50% 75% 100%
Of the meal eaten at home, what percentage are prepackaged? 10% 25% 50% 75% 100%

If you eat meals at home, where do you shop for groceries?

Do you feel satisfied with your ability to prepare healthy, tasty foods?

How often do you eat breakfast? 10% 25% 50% 75% 100%

Do you drink the following on a regular basis (please circle):

Water Daily amount: Source (tap, bottled, filtered, etc.)
Soda Daily amount:

Green tea	Daily amount:	Milk/cream?	Sweetener?
Black tea	Daily amount:	Milk/cream?	Sweetener?
Herb tea	Daily amount:	Milk/cream?	Sweetener?
Coffee	Daily amount:	Milk/cream?	Sweetener?
Juice	Daily amount:		
Beer	Daily amount:		
Wine	Daily amount:		
Alcohol	Daily amount:		

What foods do you hate:

What foods do you love:

Do you have any concerns about your relationship with food?

Review of Systems

Please circle correct answer for the conditions below:

Y = current condition ***P = past condition***

Skin

Rashes	Y P	Eczema/hives	Y P	Itching	Y P
Acne/boils	Y P	Color changes	Y P	Lumps	Y P
Night sweats	Y P				

Head

Headache	Y P	Head injury	Y P

Eyes

Impaired vision	Y P	Glasses/contacts	Y P	Eye pain	Y P
Tearing/dryness	Y P	Double vision	Y P	Glaucoma	Y P
Cataracts	Y P				

Ears

Impaired hearing	Y P	Ringing	Y P	Earache	Y P
Dizziness	Y P	Frequent infections	Y P		

Nose and sinuses

Frequent colds	Y P	Nose bleeds	Y P	Stuffiness	Y P
Hay fever	Y P	Sinus problems	Y P		

Mouth and throat

Frequent colds	Y P	Nose bleeds	Y P	Gum problems	Y P
Hoarseness	Y P	Dental cavities	Y P	Frequent sore throat	Y P

Neck

Lumps Y P
Goiter Y P
Swollen glands Y P
Pain or stiffness Y P

Respiratory

Cough Y P
Wheezing Y P
Pneumonia Y P
Difficult breathing Y P
Shortness of breath Y P
Spitting up blood Y P
Asthma Y P
Emphysema Y P
Pain on breathing Y P
Smoke cigarettes Y P
How many packs/day
Year started:
Year quit:
Sputum Y P
Bronchitis Y P
Tuberculosis Y P

Cardiovascular

Heart disease Y P
Murmurs Y P
Swelling of ankles Y P
Angina Y P
Palpitations Y P
Chest pain Y P
High blood pressure Y P
Rheumatic fever Y P

Gastrointestinal

Trouble swallowing Y P
Change in appetite Y P
Blood in stool Y P
Liver disease Y P
Bowel movements: how often?___________
Hemorrhoids Y P
Heartburn Y P
Nausea Y P
Belching/passing gas Y P
Gall bladder disease Y P
Is this a change?
Loose stools Y P
Change in thirst Y P
Vomiting Y P
Jaundice (yellow skin) Y P
Ulcer Y P
Pain with bowel movement Y P
Hard, difficult to pass stools Y P

Urinary

Pain on urination Y P
Inability to hold urine Y P
Increased frequency Y P
Frequent infections Y P
Frequency at night Y P
Kidney stones Y P

Female reproductive

Age menses began? ___________
Average # of days? ___________
Length of cycle? ________

Last PAP
Normal or Abnormal?
History of abnormals?
When and what treatment?

Bleeding between periods Y P
Painful menses Y P
Menopausal symptoms Y P
Sexually transmitted infections Y P
Are you sexually active? Y P
Birth control Y P
Irregular cycles Y P
Excessive flow Y P
Sexual difficulties Y P
Herpes Y P
Type of birth control ______
Pain during intercourse Y P
Difficulty conceiving Y P
Genital warts Y P

Does your birth control method protect against sexually transmitted infections?

What percentage of the time do you use that method 10% 25% 50% 75% 100%

Do you have any questions about birth control you would like to discus today?

Sexual orientation: □Heterosexual □Bisexual □Homosexual

Any events in the your sexual history or development that you would like to share?

Last time screened for sexual transmitted infections?
What tests and results (if known):

Number of pregnancies ______Number of live births ______ Number of miscarriage ___________ Number of abortions ___________

Describe your birth experience:

Did you breastfeed? How Long? Any difficulties?

Do you do self breast exams? Y N Lumps Y P
Breast pain or tenderness Y P Nipple discharge Y P
Family history of breast cancer Y N

If yes, which relative: Age at diagnosis: Type and treatment:

Last mammogram Result

Male reproductive

Hernias Y P Testicular masses Y P Testicular pain Y P
Are you sexually active? Y P Sexual difficulties Y P Prostate concerns Y P
Discharge Y P Sexually transmitted infections Y P Lesions or sores Y P

What methods, if any, do you use as birth control and/or to protect against sexually transmitted infections?

What percentage of the time do you use that method 10% 25% 50% 75% 100%
Last time screened for sexual transmitted infections?
What tests (if known):

Do you have any questions about birth control/sexually transmitted disease proteection you would like to discus today?

Sexual orientation: Heterosexual Bisexual Homosexual

Any events in the your sexual history or development that you would like to share?

Musculoskeletal

Joint pain or stiffness	Y P	Arthritis	Y P	Broken bones	Y P
Muscle pain/cramps	Y P	Osteoporosis	Y P	Osteopenia	Y P

Peripheral vascular

Deep leg pain	Y P	Cold hands/feet	Y P	Varicose veins	Y P
Thrombophlebitis	Y P				

Neurological

Fainting	Y P	Seizure	Y P	Paralysis	Y P
Muscle weakness	Y P	Loss of memory	Y P		
Numbness/tingling	Y P	Family history of stroke	Y N		
ADD/ADHD	Y P				

Emotional

Depression	Y P	Anxiety or nervousness	Y P	Anti-depressants	Y P
Mood swings	Y P	Tension	Y P		
Counseling/therapy	Y P	Panic attacks	Y P	Alcohol abuse	Y P
Drug abuse	Y P	Eating disorder	Y P		

Any questions or concerns about your emotional health that you would like addressed today?

Endocrine

Hypothyroid	Y P	Hyperthyroid	Y P	Diabetes	Y P
Excessive thirst	Y P	Excessive hunger	Y P	Family history of diabetes	Y N
Heat/cold intolerance	Y P				

Blood

Anemia	Y P	Easy bleeding or bruising	Y P

Is there anything else that you think I should know in order to provide you the best possible care?