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

Respiratory

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

Cardiovascular

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

Gastrointestinal

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

Urinary

Pain on urination	Y P	Increased frequency	Y P	Frequency at night	Y P
Inability to hold urine	Y P	Frequent infections	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 Irregular cycles Y P Pain during intercourse Y P
Painful menses Y P Excessive flow Y P Difficulty conceiving Y P
Menopausal symptoms Y P Sexual difficulties Y P
Sexually transmitted infections Y P Herpes Y P Genital warts Y P
Are you sexually active? Y P
Birth control Y P Type of birth control _____

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?