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*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):

General Health: Poor Average Gender: Good Excellent

Siblings (age or age of death):

General Health: Poor Average Gender: Good Excellent

Siblings (age or age of death):

General Health: Poor Average Gender: Good Excellent

CHILDHOOD ILLNESSES

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

Rheumatic fever	Diphtheria	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 _____

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 environmental 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 abnormal? _____ 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 discuss 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 protection you would like to discuss 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
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Is there anything else that you think I should know in order to provide you the best possible care?