Adonai Optimal Health and Wellness

11 Woodland Road. Madison, CT 06443
(203) 318-5200

Signature on File

PLEASE READ AND INITIAL EACH LINE

____ I authorize use of this form on ALL of my insurance submissions

____ I authorize release of information to all of my insurance companies

____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies and authorize payment directly to my doctor.

____ I authorize Access to Health to obtain medical information from other medical professionals including test results.

____ I permit a copy of this authorization be used in place of the original.

_____ _____

Patient Name (Printed) Patient Signature or Parent/Guardian

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06443

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Phone(203) 318-5200

Fax (203) 318-5203

Please fill out the following as thoroughly as possible. Print clearly and mark anything you don't understand with a question mark. This questionnaire asks about your physical, mental and emotional health, all of this information will then assist the doctor in providing you with the best naturopathic care possible.

Personal Information

Today's Date_____ Name _____

Phone #_____ Age _____ Date of Birth ____/____/____ Sex M / F

Address _____ City_____ State_____ Zip_____

Social Security #____-____-_____ Email Address _____

When did you last receive medical care? _____

Where? _____ Why? _____

Doctor(s) currently seen:

Name_____ Practice Name _____

Address _____ City_____ State_____ Zip_____

Office Phone (___) _____ Office Fax (___) _____

Name_____ Practice Name _____

Address _____ City_____ State_____ Zip_____

Office Phone (___) _____ Office Fax (___) _____

Health History

Vaccinations/ Immunization

Y N Polio Y N Pertussis Y N Chicken Pox

Y N Tetanus Y N Diphtheria Y N MMR (measles/mumps/rubella)
Y N Hepatitis B Other_____

Childhood Illnesses-

Y N Rubella Y N Measles Y N Roseola
Y N Mumps Y N Chicken Pox Y N Whooping cough
Y N Polio Y N Eczema Y N Rheumatic Fever
Y N Diphtheria Y N Asthma Y N Scarlet Fever
Other_____

List any known allergies (environmental, food, drug) and reaction: _____
_____
_____

Do you currently take any of the following medications? Check all that apply:

__Aspirin __Ibuprofen or acetaminophen __Sleeping pills __Medicine to stay awake
__Laxatives __Appetite depressants __Antacid __Antihistamine
__Cortisone __Birth control pills/patch/ring __Antibiotics __Hormone/thyroid med

List all medications (prescriptions), vitamin, and other supplements you are currently or have taken in the past year. Attach additional sheet if needed.

Medication	Dosage/Frequency	Dates	Reason for Taking	Who Prescribed

If any of the following apply to you, please fill in known information, add other procedures if needed:

Procedure	Reason	Date	Outcome	Procedure	Reason	Date	Outcome
Hospitalization				Hospitalization			
Surgery				Surgery			
X-Ray				MRI			
Bone Scan				EKG			
Endoscopy				Echocardiogram			
Colonoscopy				EEG			
Rectal Exam				Mammogram			

Current Health History-

_____

Please check next to appropriate item(s), or circle as indicated:

Head- eyes, ear, nose, throat

Now	Past		Now	Past		Now	Past	
___	___	headaches	___	___	dizziness	___	___	runny nose
___	___	blurry vision	___	___	fainting/blackouts	___	___	loss of smell
___	___	halo around objects	___	___	loss of balance	___	___	nosebleeds
___	___	eye pain/red eye	___	___	ringing in ears	___	___	neck lumps
___	___	cataracts/glaucoma	___	___	difficulty hearing	___	___	earaches

Head- eyes, ear, nose, throat cont'd

Now	Past		Now	Past		Now	Past	
___	___	grinding teeth	___	___	cold/canker sores	___	___	sore throat
___	___	dental problems	___	___	difficulty swallowing	___	___	hoarse voice

Chest- lungs, heart

Now	Past		Now	Past		Now	Past	
___	___	wheezing	___	___	chest colds	___	___	palpitations
___	___	shortness of breath	___	___	unexplained fever	___	___	chest pain
___	___	cough up blood	___	___	night sweats	___	___	swollen feet
___	___	cough up phlegm	___	___	rapid/skipped beats	___	___	high blood pressure

Abdomen- stomach, liver

Now	Past		Now	Past		Now	Past	
___	___	indigestion	___	___	pain in abdomen	___	___	constipation
___	___	light colored stool	___	___	nausea	___	___	diarrhea
___	___	rectal pain or itch	___	___	loss of appetite	___	___	vomiting
___	___	frequent belching/gas	___	___	yellow skin/jaundice	___	___	excessive appetite

Genitourinary- reproductive organs, bladder

Now	Past		Now	Past		Now	Past	
___	___	frequent urination	___	___	pain w/urination	___	___	blood in urine
___	___	urge to urinate	___	___	weak urine stream	___	___	kidney stones
___	___	incontinence	___	___	groin itching	___	___	genital warts
___	___	rash/itching	___	___	sexual difficulty	___	___	STD/STI

Musculoskeletal- joints, bones

Now	Past		Now	Past		Now	Past	
___	___	sore/swollen joints	___	___	leg cramps	___	___	restless legs
___	___	aching muscles	___	___	weakness	___	___	broken bones
___	___	numbness	___	___	tingling	___	___	hives
___	___	rash/itching	___	___	bruising	___	___	acne

Nervous system and Mental Emotional

Now	Past		Now	Past		Now	Past	
___	___	anxiety	___	___	loss of memory	___	___	nervousness

___ ___ ADD/ADHD ___ ___ lonely ___ ___ depressed
___ ___ hopelessness ___ ___ frequent crying ___ ___ frequent worry
___ ___ difficulty relaxing ___ ___ shy/sensitive ___ ___ angered easily
___ ___ work problems ___ ___ family problems ___ ___ suicidal
___ ___ difficulty with decisions ___ ___ scary thoughts/dreams ___ ___ annoyed by little things

Men only

Now Past Now Past Now Past
___ ___ painful testes ___ ___ swelling in testes ___ ___ discharge
___ ___ impaired fertility ___ ___ prostate problem ___ ___ sexual abuse
___ ___ self-testicular exam ___ ___ sexually active ___ ___ condom use

Sexual orientation: Heterosexual___ Homosexual ___ Bisexual___ Transgendered ___

Women only

Now Past Now Past Now Past
___ ___ missed period(s) ___ ___ irregular bleeding ___ ___ chronic yeast
___ ___ frequent vaginitis ___ ___ breast pain/lump ___ ___ PMS
___ ___ PCOS ___ ___ endometriosis ___ ___ sexual abuse
___ ___ vaginal dryness ___ ___ HRT ___ ___ hot flashes
___ ___ genital irritation ___ ___ vaginal discharge ___ ___ infertility
___ ___ difficulty w/exams ___ ___ heavy/light menses ___ ___ nipple discharge
___ ___ painful intercourse ___ ___ bearing down feelings ___ ___ new facial hair/hair loss
___ ___ sexually active ___ ___ irregular bleeding ___ ___ chronic yeast

Sexual orientation: Heterosexual___ Homosexual ___ Bisexual___ Transgendered ___
Number of pregnancies ____ live births ____ miscarriages ____ abortions____
Age of first menses ____ Do you perform self breast exams? Y / N Date of last pap ___/___/___
Usual length of cycle (from first day of bleeding to next) period ___ Date of last menses ___/___/___
Do you use birth control? (List all types used) _____

List any other health issues/symptoms: _____

_____

_____

_____

Family History_____

If you or anyone in your immediate family has or had any of the following conditions, please indicate who was affected (self, mother, father, sister, brother, child):

Cancer (type) _____ Diabetes_____
Anemia_____ Arthritis_____
Heart Disease_____ Asthma/hay fever/hives _____
Stroke_____ Osteoporosis_____
High Blood Pressure_____ Depression_____
Alcoholism or substance abuse_____ Autoimmune Disease_____

Attempted suicide_____ Kidney disease_____

Mental illness_____ Seizures/ Epilepsy_____

Glaucoma_____ Gout_____

Other_____ Other_____

Social History

Are you currently in a relationship? _____ Is this a satisfying relationship? _____

With whom do you live? (List all members of household) _____

Does your income meet your monthly needs? _____

Have you traveled outside the U.S. in the past 5 years? Where? _____

Do you camp? _____ Where? _____

Military service? _____ When and where? _____

Social History cont'd

Alcohol use: _____drinks/week Tobacco use: ____packs/day ___cigars/day ____chew/day

Recreational drug use: Y / N List all used currently: _____ Past use: _____

Do you want help to quit any of these substances? _____

Exercise _____ hours/week What types? _____

What are your hobbies? _____

Do you take time to relax? Y / N How? _____ Number of hours you watch TV____/day

Do you have religious/spiritual belief? Y / N Do you practice regularly? _____

Major life changes in the last year_____

Level of stress __low__ medium__ high How do you handle stress? _____

Diet

Are you satisfied with your diet? Y / N Circle # of meals eaten per day: 1 2 3 more than 3

Commonly eaten foods in your day to day diet _____

_____

Food excluded from your diet _____

Caffeinated drinks (coffee, tea, soda) _____/day

Foods/drinks that you crave: _____

Are you thirsty? _____ Preferred temperature of drinks: _____

Sleep

Hours/night _____ Is this enough? Y / N Do you have any problems with your sleep? _____

Any recurring dreams? _____

Any position that you always sleep in? Or cannot sleep in? _____

Environmental Exposures

Circle any of the following that you are exposed to:

gas heat oil heat wood stove electric heat air conditioning tap water dust

mold excessive dampness/dryness animal / pet hair poor ventilation amalgam fillings

List any other exposures:_____

_____

Environmental Exposures cont'd

Outdoor work (what type) _____

Indoor work (what type) _____

List chemicals/odors/dust you are exposed to at work currently or have been in the past (eg: toner ink, bark, dust, flour dust, hair color…) _____

_____

Hobbies or Activities

List any chemical/odors/dust you are exposed to from hobbies or have been in the past: _____

_____

Write any additional concerns or anything you'd like to include to help us get to know you better: _____

_____

_____

_____