

Adonai Optimal Health and Wellness

31 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

598 West Main St, Suite 1 Norwich, CT

06360

Access to Health Chiropractic Center

Phone (860) 889-1475

Fax (860) 889-2850

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 Hepatitis B

Y N Diphtheria
Other _____

Y N MMR (measles/mumps/rubella)

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			

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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 | |
| <input type="checkbox"/> | <input type="checkbox"/> | headaches | <input type="checkbox"/> | <input type="checkbox"/> | dizziness | <input type="checkbox"/> | <input type="checkbox"/> | runny nose |
| <input type="checkbox"/> | <input type="checkbox"/> | blurry vision | <input type="checkbox"/> | <input type="checkbox"/> | fainting/blackouts | <input type="checkbox"/> | <input type="checkbox"/> | loss of smell |
| <input type="checkbox"/> | <input type="checkbox"/> | halo around objects | <input type="checkbox"/> | <input type="checkbox"/> | loss of balance | <input type="checkbox"/> | <input type="checkbox"/> | nosebleeds |
| <input type="checkbox"/> | <input type="checkbox"/> | eye pain/red eye | <input type="checkbox"/> | <input type="checkbox"/> | ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> | neck lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | cataracts/glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | difficulty hearing | <input type="checkbox"/> | <input type="checkbox"/> | earaches |

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

- | | | | | | | | | |
|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--------------|
| Now | Past | | Now | Past | | Now | Past | |
| <input type="checkbox"/> | <input type="checkbox"/> | grinding teeth | <input type="checkbox"/> | <input type="checkbox"/> | cold/canker sores | <input type="checkbox"/> | <input type="checkbox"/> | sore throat |
| <input type="checkbox"/> | <input type="checkbox"/> | dental problems | <input type="checkbox"/> | <input type="checkbox"/> | difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> | hoarse voice |

Chest- lungs, heart

- | | | | | | | | | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|---------------------|
| Now | Past | | Now | Past | | Now | Past | |
| <input type="checkbox"/> | <input type="checkbox"/> | wheezing | <input type="checkbox"/> | <input type="checkbox"/> | chest colds | <input type="checkbox"/> | <input type="checkbox"/> | palpitations |
| <input type="checkbox"/> | <input type="checkbox"/> | shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | unexplained fever | <input type="checkbox"/> | <input type="checkbox"/> | chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | cough up blood | <input type="checkbox"/> | <input type="checkbox"/> | night sweats | <input type="checkbox"/> | <input type="checkbox"/> | swollen feet |
| <input type="checkbox"/> | <input type="checkbox"/> | cough up phlegm | <input type="checkbox"/> | <input type="checkbox"/> | rapid/skipped beats | <input type="checkbox"/> | <input type="checkbox"/> | high blood pressure |

Abdomen- stomach, liver

- | | | | | | | | | |
|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|--------------------|
| Now | Past | | Now | Past | | Now | Past | |
| <input type="checkbox"/> | <input type="checkbox"/> | indigestion | <input type="checkbox"/> | <input type="checkbox"/> | pain in abdomen | <input type="checkbox"/> | <input type="checkbox"/> | constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | light colored stool | <input type="checkbox"/> | <input type="checkbox"/> | nausea | <input type="checkbox"/> | <input type="checkbox"/> | diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | rectal pain or itch | <input type="checkbox"/> | <input type="checkbox"/> | loss of appetite | <input type="checkbox"/> | <input type="checkbox"/> | vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | frequent belching/gas | <input type="checkbox"/> | <input type="checkbox"/> | yellow skin/jaundice | <input type="checkbox"/> | <input type="checkbox"/> | excessive appetite |

Genitourinary- reproductive organs, bladder

- | | | | | | | | | |
|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|----------------|
| Now | Past | | Now | Past | | Now | Past | |
| <input type="checkbox"/> | <input type="checkbox"/> | frequent urination | <input type="checkbox"/> | <input type="checkbox"/> | pain w/urination | <input type="checkbox"/> | <input type="checkbox"/> | blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | urge to urinate | <input type="checkbox"/> | <input type="checkbox"/> | weak urine stream | <input type="checkbox"/> | <input type="checkbox"/> | kidney stones |
| <input type="checkbox"/> | <input type="checkbox"/> | incontinence | <input type="checkbox"/> | <input type="checkbox"/> | groin itching | <input type="checkbox"/> | <input type="checkbox"/> | genital warts |
| <input type="checkbox"/> | <input type="checkbox"/> | rash/itching | <input type="checkbox"/> | <input type="checkbox"/> | sexual difficulty | <input type="checkbox"/> | <input type="checkbox"/> | STD/STI |

Musculoskeletal- joints, bones

- | | | | | | | | | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|------------|--------------------------|--------------------------|---------------|
| Now | Past | | Now | Past | | Now | Past | |
| <input type="checkbox"/> | <input type="checkbox"/> | sore/swollen joints | <input type="checkbox"/> | <input type="checkbox"/> | leg cramps | <input type="checkbox"/> | <input type="checkbox"/> | restless legs |
| <input type="checkbox"/> | <input type="checkbox"/> | aching muscles | <input type="checkbox"/> | <input type="checkbox"/> | weakness | <input type="checkbox"/> | <input type="checkbox"/> | broken bones |
| <input type="checkbox"/> | <input type="checkbox"/> | numbness | <input type="checkbox"/> | <input type="checkbox"/> | tingling | <input type="checkbox"/> | <input type="checkbox"/> | hives |
| <input type="checkbox"/> | <input type="checkbox"/> | rash/itching | <input type="checkbox"/> | <input type="checkbox"/> | bruising | <input type="checkbox"/> | <input type="checkbox"/> | acne |

Nervous system and Mental Emotional

- | | | | | | | | | |
|--------------------------|--------------------------|---------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|-------------|
| Now | Past | | Now | Past | | Now | Past | |
| <input type="checkbox"/> | <input type="checkbox"/> | anxiety | <input type="checkbox"/> | <input type="checkbox"/> | loss of memory | <input type="checkbox"/> | <input type="checkbox"/> | nervousness |

<input type="checkbox"/> <input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> <input type="checkbox"/> lonely	<input type="checkbox"/> <input type="checkbox"/> depressed
<input type="checkbox"/> <input type="checkbox"/> hopelessness	<input type="checkbox"/> <input type="checkbox"/> frequent crying	<input type="checkbox"/> <input type="checkbox"/> frequent worry
<input type="checkbox"/> <input type="checkbox"/> difficulty relaxing	<input type="checkbox"/> <input type="checkbox"/> shy/sensitive	<input type="checkbox"/> <input type="checkbox"/> angered easily
<input type="checkbox"/> <input type="checkbox"/> work problems	<input type="checkbox"/> <input type="checkbox"/> family problems	<input type="checkbox"/> <input type="checkbox"/> suicidal
<input type="checkbox"/> <input type="checkbox"/> difficulty with decisions	<input type="checkbox"/> <input type="checkbox"/> scary thoughts/dreams	<input type="checkbox"/> <input type="checkbox"/> annoyed by little things

Men only

Now Past	Now Past	Now Past
<input type="checkbox"/> <input type="checkbox"/> painful testes	<input type="checkbox"/> <input type="checkbox"/> swelling in testes	<input type="checkbox"/> <input type="checkbox"/> discharge
<input type="checkbox"/> <input type="checkbox"/> impaired fertility	<input type="checkbox"/> <input type="checkbox"/> prostate problem	<input type="checkbox"/> <input type="checkbox"/> sexual abuse
<input type="checkbox"/> <input type="checkbox"/> self-testicular exam	<input type="checkbox"/> <input type="checkbox"/> sexually active	<input type="checkbox"/> <input type="checkbox"/> condom use

Sexual orientation: Heterosexual ___ Homosexual ___ Bisexual ___ Transgendered ___

Women only

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