BACK TO HEALTH OF BRANFORD LLC

Dr. Chrissy Davis-Allen

Patient Profile

Please complete the following questionnaire as thoroughly as possible to aid your physician in her diagnosis and treatment. This will be a part of your confidential medical record and will not be released unless you have authorized us to do so.
Adults completing this intake for infants and children: please fill out what is applicable and appropriate.
PLEASE PRINT CLEARLY.

Last Name: ___________________________ First Name: ____________________ Middle Initial: _____

Date of Birth: ______________ Age: _____ Gender (sex): _______ SSN: _______________________

Address: ____
(number, street, apt number, city, state and zip / postal code)

Home Phone: __________________Employer: ___________________Work Phone: _______________

Emergency Contact: _________________ Relation: ______________ Phone: _____________________

Insured Patient's Information: Company: ___________________ Policy Number: _________________

Insured Patient's Name: _________________Employer: ________________ SSN: ________________

(Fill out if different from above. If you are not the primary name on the policy.)

Present Health Concerns (In order of importance): Duration:

1. ______________________________________ ____________________________

2. ______________________________________ ____________________________

3. ______________________________________ _____________________________

Social History (Please circle, or complete if applicable):

Single   Married   Significant Other   Name of husband / wife / partner ______________________

If sexually active, please describe birth control methods currently used:_________________________

Your Occupation: _______________________ Your Education: _____________________________

For Females:

Spontaneous abortion (miscarriage): __________________________
Number of Pregnancies: ___________________________________
Length of Pregnancy (ies) in weeks:___________________________

Number of Children (names and ages)
____

Hospital or Home Birth:
____

Vaginal or C-Section Delivery:
____

What level of change to your living habits are you willing to make to improve your health?
(circle one)

Whatever it takes.   Significant change   Some change   No change

How long do you think it is going to take?
____
____

Known Allergies [drugs, food, environmental (grass, pollen, etc.)]:
____
____
____
____

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Vitamins / Herbs / Supplements (Currently Taking)

Name / Type	Reason for Taking	Dose / (mg / etc)	For how long	Who Prescribed

Current Medication (prescription and over the counter, including birth control pills)

Name of Drug	Reason for drug	Dose (mg / etc)	For how long	Prescribing Dr.

Regular Exercise / Movement:

Types (running,weights,etc)	Time per session (minutes / hrs.)	Frequency (daily / weekly)	Practices for how long (weeks / monthly / yrs.)
___________________	_________________	______________	_____________________
___________________	_________________	_______________	______________________
___________________	_________________	_______________	______________________
___________________	_________________	_______________	______________________

Sleep Habits:

How many hours per night: ________Do you wake refreshed? ________If not, why? __________________

Do you have problems (circle): Falling asleep Staying asleep Waking up

Average energy level per week (circle one)

1 2 3 4 5 6 7 8 9 10
(Lowest) (Highest)

Average stress level per week (circle one)

1 2 3 4 5 6 7 8 9 10
(Lowest) (Highest)

How do you cope with stress? ____

Do you talk to anyone about your problems: ___________ who? __________________________________

Who else might you confide in, or seek advice from? ____

What are some things you do for fun and how often? ____

____

List any chemical, fumes, dusts etc., that you are or have been repeatedly exposed to: _______________

____

Diet History (includes any liquids tea, coffee, etc., in description; in table below, list number of servings).

What was breakfast yesterday? ____

What was lunch yesterday? ____

What was dinner yesterday? ____

List snacks you had yesterday? ____

How many glasses of plain water do you drink per day? ____filtered ____distilled _____well water ___

Any special dietary restrictions? ____

	Never	Occasionally	Weekly	Daily
Red Meat	____	____	____	____
Fish	____	____	____	____
Chicken	____	____	____	____
Fresh Fruit	____	____	____	____
Vegetables	____	____	____	____
Dairy Products	____	____	____	____
Whole Grain	____	____	____	____
Sweets	____	____	____	____

Medical / Health History:

Primary Care Doctor / Provider (if any): ____________________________ Date last seen: ___________

Reason for seeing: ____

Office Name: _______________________________Doctor's phone number: _______________________

Doctor's full address: ____

____

Other Current Provider(s) name: Type For what health reason Phone

Other Current Provider(s) name:	Type	For what health reason	Phone
____________________________	____	____________________	_________________
____________________________	____	____________________	_________________
____________________________	____	____________________	__________________
____________________________	____	____________________	__________________

Date of last physical exam: __________________ Results: normal, other ____________________________

Date of last urine test: _____________________ Results: normal, other ____________________________

Date of last blood work: ____________________ Results: normal, other ____________________________

Date of last PAP / pelvic exam (females): ________Results: _____________________________________

Do you perform monthly self breast exams? ___________

Date of last mammogram: ___________________Findings: ______________________________________

Date of last menstruation: ____

If you do not cycle, date of start of menopause: ____

Are you pregnant (females): ________________ If so how far along: _______________________________

Date of last prostate exam (males): ____

Do you perform monthly testicular exams? ____

How would you describe your general health: ____

____

Outpatient Procedures / Hospitalizations (surgeries / special diagnostic studies)

Type (surgery / study)	Date	Reason for procedure / admission	Outcome / results
__________________	______	____________________________	___________________
__________________	______	____________________________	___________________
__________________	______	____________________________	___________________
__________________	______	____________________________	___________________
__________________	______	____________________________	___________________

Major Illnesses / emotional or physical trauma / accidents (If not already listed):

Type	Date	Treatment received	Outcome
________________	________	_______________________	___________________
________________	________	_______________________	___________________
________________	________	_______________________	___________________
________________	________	_______________________	___________________

Vaccination / immunization history:
Please list conventional and homeopathic immunizations: type / date / year:

____

____

____

____

Eliminations

	Bowel Movement Habits
Frequency: (how often)	__________________
Color: Black, brown, yellow, green, white:	___________________
Consistency: Hard, formed, soft, watery	___________________
Any mucus or blood: (which)	___________________
Does it pass easily? (any straining involved)	____________________

	Urine Habits
Frequency (how many times per 24 hour period)	____________________
Color: Dark yellow, light yellow, green, colorless	____________________
Character: clear, cloudy, concentrated, dilute	____________________
Any blood or sediment (which)	____________________
Any pain, incontinence, difficulty with stream?	_____________________

Personal Habits (check or describe in the following boxes):

	Tobacco	Alcohol	Caffeine	Recreational drugs
Currently use:	__________	________	_________	__________________________
Previously used:	__________	________	_________	__________________________
Never used:	__________	________	_________	__________________________
How much / many: (per day, week, month, etc.	__________	________	_________	__________________________
Specify type: (filtered / not beer / wine / mixed drinks / tea / coffee)	___________	________	__________	___________________________
For how long: (months / years)	___________	_________	__________	____________________________
Date quit:	___________	_________	__________	_____________________________

Review of Systems (check if you've had any of the following):

____anemia
____blood diseases
____fatigue (affecting daily living)
____dizziness (more than 5 seconds)
____frequent headaches
____loss of hearing
____ringing in ears (more than 5 seconds)
____loss of vision
____eye pain
____frequent sore throat
____lasting numbness
____lasting weakness
____lasting tingling
____nervousness / depression
____skin problems
____brittle nails
____hair loss
____allergies
____frequent sinus infections
____cancer
____asthma
____difficulty breathing
____chronic bronchitis
____tuberculosis
____stomach ulcers
____constipation
____diarrhea (infectious)
____diarrhea (bloody)
____lasting nausea
____recurrent vomiting

____chest pain
____heart disease
____heart failure
____irregular heart beat
____hemorrhoids
____easy bruising
____frequent nosebleeds
____varicose veins
____poor circulation
____stroke
____kidney failure
____kidney infection
____kidney stones
____sexually transmitted diseases
____thyroid disorder
____diabetes
____swelling of ankles
____liver disease
____hepatitis
____arthritis
____neck pain / stiffness
____low back pain / stiffness
____bursitis
____hot and swollen joints
____prostate enlargement
____cramps / backache (female)
____excessive menstrual flow
____hot flashes
____irregular cycles
____fibrocystic breasts

Family History:
(Using the following key, designate which family member has had the following. List type where parentheses are presents).

M = Mother F = Father B = Brother S = Sister G = Grandparents C = Child

Condition	Whom	Condition	Whom	Condition	Whom
Allergies	_______	Diabetes	_______	Kidney Disease	______
Alcoholism	_______	Depression	_______	Mental Disorder	______
Anemia	_______	Cancer	_______	Obesity	______
Arthritis (rheumatoid)	_______	Epilepsy	_______	Stroke	______
Arthritis (osteo)	______	Disease	_______	Thyroid disorders	______
Auto Immune Disease	______	Hepatitis	_______	Other ( )	______
Bleeding Tendency	____	High Blood Pressure	_____	Other ( )	______

Anything else you want us to know about? ____

____

THANK YOU for your time and patience in filling out this rather lengthy form!