Dr. Carolyn McGaughey, N.D.
7105 Morro Road
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Ph/ 805-461-8822
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Adult Intake Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # (home): _____(cell): _____ (work): _____ ext:_____

Email address: _____ Skype name (optional): _____

Age: ____ Date of Birth:_____ Gender: F / M Education: _____

Married: _____ Separated: _____ Divorced: _____ Widowed: _____ Single: _____ Partnership:_____

Live with: Spouse: _____ Partner: _____ Parents: _____ Children: _____ Friends: _____ Alone: _____

Occupation: _____

Employer Name and Address: _____

_____

How did you hear about us? _____

Have any family members been a patient of Dr. McGaughey? _____

Emergency contact: _____ Relationship: _____

Phone: _____ Address: _____

_____

CONTEXT OF CARE REVIEW

The success of any wellness journey is only possible when the doctor has a complete understanding of her patient's physical, mental, and emotional health. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach to health care?

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CONTEXT OF CARE REVIEW, cont.

What *three* expectations do you have from *this* visit to our clinic?

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptom that relate to your lifestyle? Rate from 0 to 10, with 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

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 that you feel are self-destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

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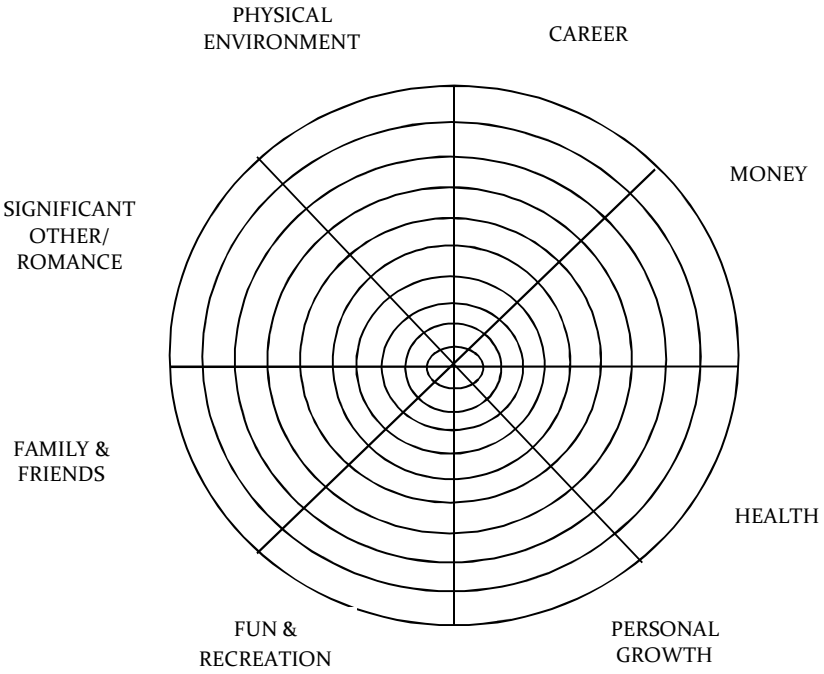
Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



Are you currently receiving healthcare? Yes / No
If yes, where and from whom?

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) _____

6) _____

7) _____

Do you have any known contagious diseases at this time? Yes / No If yes, what ?

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FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say whom)

Cancer	Diabetes	Heart Disease	High Blood
Kidney disease	Epilepsy	Arthritis	Pressure
Tuberculosis	Stroke	Anemia	Glaucoma
Asthma	Hay fever	Hives	Mental Illness

Any other relevant family history? _____

What is your family heritage? _____

CHILDHOOD ILLNESSES

Birth city & state: _____ Birth time: _____ Birth weight: _____

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

Rheumatic fever	Measles	Chicken Pox
German Measles	Scarlet Fever	Meningitis
Diptheria	Mumps	Pertussis

HOSPITALIZATIONS/ SURGERY/ IMAGING/ OTHER STUDIES

Please list the following: any hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs, or other studies you have had performed (please attach list if not enough space).

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental or chemical substances? _____

_____

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CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives	Tranquilizers	Cortisone
Pain relievers	Hormone Replacement	Thyroid medication
Antibiotics	Antacids	
Birth Control Pills	Sleeping pills	

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking with dosages if possible (or attach your own list):

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

GENERAL

Height: _____ Weight: _____ lbs Weight one year ago: _____ lbs

Maximum weight: _____ lbs When: _____

When during the day is your energy the best? _____ Worst: _____

Main interests and hobbies: _____

_____

Exercise: Y / N If yes, what kind and how often? _____

Watch TV: Y / N If yes, how many hours? _____ Read: Y / N If yes, how many hours? _____

Do you have a religious or spiritual practice? Y / N If yes, what kind? _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

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FOR THE FOLLOWING, PLEASE CIRCLE

Y= yes/ condition you have now N= no/never had P= problem in the past S= sometimes a problem now

GENERAL

Do you sleep well?	Y	N	P	S
Average 6-8 hours?	Y	N	P	S
Awake rested?	Y	N	P	S
Have a supportive relationship?	Y	N	P	S
Have a history of abuse?	Y	N	P	S
Experienced a major trauma?	Y	N	P	S
Use recreational drugs?	Y	N	P	S
Treated for drug dependence?	Y	N	P	S
Use alcoholic beverages?	Y	N	P	S
Use tobacco?	Y	N	P	S

If in the past, how many years? _____

How many packs per day? _____

Do you enjoy your work?	Y	N	P	S
Take vacations?	Y	N	P	S
Spend time outside?	Y	N	P	S
Eat three meals a day?	Y	N	P	S
Do you go on diets often?	Y	N	P	S
Ever had an eating disorder?	Y	N	P	S
Do you eat out often?	Y	N	P	S
Do you drink coffee?	Y	N	P	S
Drink black/ green tea?	Y	N	P	S
Drink soda or energy drinks?	Y	N	P	S
Do you eat refined sugar?	Y	N	P	S
Do you add salt to your food?	Y	N	P	S

NEUROLOGIC

Seizures?	Y	N	P	S
Muscle weakness?	Y	N	P	S
Loss of memory?	Y	N	P	S
Vertigo or dizziness?	Y	N	P	S
Paralysis?	Y	N	P	S
Numbness or tingling?	Y	N	P	S
Easily stressed?	Y	N	P	S
Loss of balance?	Y	N	P	S

ENDOCRINE

Hypothyroid?	Y	N	P	S
Hypoglycemia?	Y	N	P	S
Excessive thirst?	Y	N	P	S

ENDOCRINE, cont.

Fatigue?	Y	N	P	S
Heat or cold intolerance?	Y	N	P	S
Hyperthyroid?	Y	N	P	S
Diabetes?	Y	N	P	S
Excessive hunger?	Y	N	P	S
Seasonal depression?	Y	N	P	S
Difficulty exercising?	Y	N	P	S

IMMUNE

Reactions to immunizations?	Y	N	P	S
Chronically swollen glands?	Y	N	P	S
Slow wound healing?	Y	N	P	S
Chronic fatigue syndrome?	Y	N	P	S
Chronic infections?	Y	N	P	S
Night sweats?	Y	N	P	S

EARS

Impaired hearing?	Y	N	P	S
Ringing in ears?	Y	N	P	S
Dizziness?	Y	N	P	S
Ear aches?	Y	N	P	S

EYES

Impaired vision?	Y	N	P	S
Cataracts?	Y	N	P	S
Glaucoma?	Y	N	P	S
Spots in vision?	Y	N	P	S
Color blindness?	Y	N	P	S
Tearing or dryness?	Y	N	P	S
Eye pain or strain?	Y	N	P	S

HEAD

Headaches?	Y	N	P	S
Migraines?	Y	N	P	S
Head injury?	Y	N	P	S
Jaw or TMJ problems?	Y	N	P	S

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NOSE AND SINUS

Frequent colds?	Y	N	P	S
Stuffiness?	Y	N	P	S
Sinus problems?	Y	N	P	S
Nose bleeds?	Y	N	P	S
Hayfever?	Y	N	P	S
Loss of smell?	Y	N	P	S

NECK

Lumps in neck?	Y	N	P	S
Goiter?	Y	N	P	S
Difficulty swallowing?	Y	N	P	S
Pain or stiffness in neck?	Y	N	P	S

MOUTH AND THROAT

Frequent sore throat?	Y	N	P	S
Copious saliva?	Y	N	P	S
Sore tongue or lips?	Y	N	P	S
Hoarseness?	Y	N	P	S
Jaw clicks?	Y	N	P	S
Teeth grinding?	Y	N	P	S
Gum problems?	Y	N	P	S
Dental cavities?	Y	N	P	S

SKIN

Rashes?	Y	N	P	S
Acne/ boils?	Y	N	P	S
Changes in skin color?	Y	N	P	S
Lumps or bumps on skin?	Y	N	P	S
Eczema or hives ?	Y	N	P	S
Itching?	Y	N	P	S
Perpetual hair loss?	Y	N	P	S

RESPIRATORY

Cough?	Y	N	P	S
Sputum?	Y	N	P	S
Asthma?	Y	N	P	S
Wheezing?	Y	N	P	S
Bronchitis?	Y	N	P	S
Coughing up blood?	Y	N	P	S
Shortness of breath?	Y	N	P	S
Shortness of breath when lying down?	Y	N	P	S
Pain in breathing?	Y	N	P	S

RESPIRATORY, cont.

Emphysema?	Y	N	P	S
Tuberculosis?	Y	N	P	S

GASTROINTESTINAL

Trouble swallowing?	Y	N	P	S
Change in thirst?	Y	N	P	S
Change in appetite?	Y	N	P	S
Nausea/vomiting?	Y	N	P	S
Ulcer?	Y	N	P	S
Jaundice?	Y	N	P	S
Gallbladder disease?	Y	N	P	S
Liver disease?	Y	N	P	S
Hemorrhoids?	Y	N	P	S
Pancreatitis?	Y	N	P	S
Heartburn?	Y	N	P	S
Abdominal pain or cramps?	Y	N	P	S
Belching or passing gas?	Y	N	P	S
Constipation?	Y	N	P	S
Loose stools?	Y	N	P	S
Bowel movements: how often? _____				
Is this a change?	Y	N	P	S
Black stools?	Y	N	P	S
Blood in stools?	Y	N	P	S

Date of last colonoscopy: _____

MENTAL/EMOTIONAL

Treated for emotional problems?	Y	N	P	S
Depression?	Y	N	P	S
Anxiety or nervousness?	Y	N	P	S
Poor concentration?	Y	N	P	S
Do you have mood swings?	Y	N	P	S
Considered suicide?	Y	N	P	S
Attempted suicide?	Y	N	P	S
Tension?	Y	N	P	S
Memory problems?	Y	N	P	S

URINARY

Increased frequency of urination?	Y	N	P	S
Inability to hold urine?	Y	N	P	S
Pain in urination?	Y	N	P	S
Frequency at night?	Y	N	P	S
Frequent UTI's?	Y	N	P	S
Kidney stones?	Y	N	P	S

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MUSCULOSKELETAL

Joint pain or stiffness?	Y	N	P	S
Arthritis?	Y	N	P	S
Broken bones?	Y	N	P	S
Weakness?	Y	N	P	S
Muscle spasms or cramps?	Y	N	P	S
Sciatica?	Y	N	P	S

BLOOD

Anemia?	Y	N	P	S
Easy bleeding or bruising?	Y	N	P	S
Cold hands/feet?	Y	N	P	S
Deep leg pain?	Y	N	P	S
Thrombophlebitis?	Y	N	P	S
Varicose veins?	Y	N	P	S

FEMALE REPRODUCTIVE

Age of first menses: _____

Age of last menses (if menopausal) or date of last menstrual period (if cycling): _____

Length of cycle (days): _____

Duration of menses (days): _____

Are your cycles regular?	Y	N	P	S
Painful menses?	Y	N	P	S
Heavy or excessive flow?	Y	N	P	S
PMS?	Y	N	P	S

Symptoms: _____

Bleeding between cycles?	Y	N	P	S
Clotting?	Y	N	P	S
Endometriosis?	Y	N	P	S
Ovarian cysts?	Y	N	P	S
Vaginal odor?	Y	N	P	S
Vaginal discharge?	Y	N	P	S

Date of last pap smear: _____

Abnormal PAP?	Y	N	P	S
Cervical dysplasia?	Y	N	P	S
Are you sexually active?	Y	N	P	S

Sexual orientation: _____

Birth control?	Y	N	P	S

Type: _____

Pain during intercourse?	Y	N	P	S
Gonorrhea?	Y	N	P	S

FEMALE REPRODUCTIVE, cont.

Chlamydia?	Y	N	P	S
Genital warts?	Y	N	P	S
Syphilis?	Y	N	P	S
Difficulty conceiving?	Y	N	P	S

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____

Number of abortions: _____

Do you do self breast exams?	Y	N	P	S

Date of last mammogram: _____
(if applicable)

Breast pain/ tenderness?	Y	N	P	S
Breast lumps?	Y	N	P	S
Nipple discharge?	Y	N	P	S
Menopausal symptoms?	Y	N	P	S

MALE REPRODUCTIVE

Are you sexually active?	Y	N	P	S

Sexual orientation: _____

Birth control?	Y	N	P	S

Type: _____

Discharge or sores?	Y	N	P	S
Chlamydia?	Y	N	P	S
Gonorrhea?	Y	N	P	S
Genital warts?	Y	N	P	S
Herpes?	Y	N	P	S
Syphilis?	Y	N	P	S
Hernias?	Y	N	P	S
Testicular masses?	Y	N	P	S
Testicular pain?	Y	N	P	S
Prostate disease?	Y	N	P	S
Impotence?	Y	N	P	S
Premature ejaculation?	Y	N	P	S

Date of last prostate exam: _____
(if applicable)