Sara Frawley N.D.
850 N. Main St Ext, Bldg 2 Suite 3C
Wallingford, CT 06492

Dr. Sara's Male Intake Form_2019

General Information

Best phone number to reach you at: * _____

Preferred method of contact : * ☐ Phone Call ☐ Text Message ☐ Email

Mailing address (street with number, town, zip code) * _____

How were you referred to Dr. Sara? * ☐ Patient Referral ☐ Yelp/Google ☐ Facebook/Website ☐ Insurance ☐ Friend or Family Member ☐ Others _____

If you were referred by a current patient of Dr. Sara's please let us know by who so we can contact them to say thanks _____

Health Insurance Provider * _____

Do you have a PPO or HMO policy * ☐ PPO ☐ HMO

Insurance policy number: * _____

Credit Card Number (only charged for drop ship supplements orders and/or late appointment cancellations or no shows) * _____

Credit Card Expiration Date (mm/yy) * _____

Credit Card CVV Code * _____

Billing Zip Code * _____

Marital status * ☐ Single ☐ Married ☐ In a relationship

Height : * _____

Weight : * _____

Occupation : * _____

Emergency Contact Name : * _____

Phone : * _____

Relationship : * _____

Medical History

Primary health care provider : * _____

Other healthcare providers: * _____

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List your chief health concerns in the order of importance to you. Also include when they started. *

List any medical diagnosis you have received (i.e. diabetes, heart disease, depression, etc.) *

List any prescription medications you take including dosages and reason for taking them *

List any over counter medications or supplements you take and the reason for taking them *

Any known allergies to medications? * ☐ Yes ☐ No

If yes, specify them

Any known food or environmental allergies? * ☐ Yes ☐ No

If yes, specify them

Are any of your allergies life threatening? * ☐ Yes ☐ No

If yes, specify them

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Have you taken any antibiotics in the last year * ☐ Yes ☐ No

If yes, how many times? _____

Family History (esp heart disease, cancer, anxiety/depression):

Ages & Chronic Diseases of:

Mother:

Father:

Sibling(s):

Grandparents:

Aunts/Uncles:

Symptoms

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For the following symptoms list how often you experience them - often, sometimes, never or in the past.

General :

Sleep disturbance *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Fatigue *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Exposure to toxic chemicals *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Iron deficiency anemia *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Head

Headaches or migraines *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Difficulty concentrating *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Memory problems *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Head injury *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Ears, Eyes, Nose, Throat

Frequent colds *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Sinus congestion or infections *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Mouth sores *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Dental/gum infections *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Cracked lips *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Recent changes in vision *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Dry eyes *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Skin

Acne *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Eczema *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Dry skin *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Easy bruising/bleeding *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Skin rashes *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Digestion

Stomach pain and or/ cramps *	☐ Often	☐ Sometimes

	☐ Never	☐ In the past
Acid reflux / heartburn *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Abdominal bloating or gas *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Nausea or vomiting *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Mental / Emotional

Mood swings or mood disorders *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Irritability *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Depression *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Anxiety/nervousness *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Cardiovascular

Heart disease *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
High blood pressure *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Heart palpitations *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Cold hands and feet *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Varicose veins *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Swelling of hands and feet *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Respiratory

Chronic Cough *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Asthma *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Shortness of breath *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Sleep apnea *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Neurological

Seizures *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Numbness and tingling *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Loss of balance *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Musculoskeletal

Joint pain or stiffness *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
	☐ Often	☐ Sometimes

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Neck/back pain *	☐ Never	☐ In the past
Muscle weakness *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Muscle spasms or cramps *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Osteopenia/osteoporosis *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Urinary

Burning or pain during urination *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Frequent urination at night *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Inability to hold urine *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Bladder infections *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Endocrine

Low libido *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Easy weight gain *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Hair loss *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Heat or cold intolerance *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Thyroid problems *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Blood sugar problems *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

For Men :

Prostate problems *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Erectile dysfunction *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Use of Viagra *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Infertility *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Difficult urination *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Lifestyle

How many alcoholic drinks per week? *	☐ None ☐ 2-4 ☐ Others _____	☐ 0-2 ☐ 4+
Do you smoke? *	☐ Yes ☐ In the past	☐ No

Rate your current stress level(10 being the highest) * ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What are the primary sources of your stress? * _____

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Do you have any dietary restrictions (religious, vegetarian, vegan, etc.)? *

Health Goals

What are your main health goals? *

How motivated are you to reach your goals? *

How willing are you to change your eating habits to reach your goal? *

- [ ] Strongly willing
- [ ] Moderately willing
- [ ] Not willing
- [ ] Cannot say

What is your timeframe for reaching your goal? *