FRESNO
HOLISTIC MEDICINE
A NATUROPATHIC WELLNESS CENTER

New Patient Intake Form

Please complete the following questionnaire. If you are uncomfortable answering any of the questions, you may leave them blank and discuss them with Dr. Tais. This will become a part of your confidential medical record and will not be released unless you have authorized us to do so.

Last name:_____ First Name:_____ Middle initial:_____

Date of birth:_____ Age:_____ Gender (sex):_____

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

Home Phone: (____)_____ Cell Phone: (___)_____

Emergency contact:_____ Phone: (_____)_____Relation:_____

Email address: _____ May we send you information via email?_____

How did you hear about Dr. Tais?_____

*What are your **main health concerns**, in order of importance to **you**?*

_____

_____

_____

What three expectations do you have for your first visit with me?

_____

_____

_____

MEDICATIONS/SUPPLEMENTS

Medications that you take	Supplements/Herbs/Vitamins that you take
1.	1.
2.	2.
3.	3.

Allergies [drugs, food, environmental (grass/pollen, etc.) Please **circle** any, which are life-threatening]:

Thank you for taking the time to fill out this questionnaire. I look forward to working with you.

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Medical / Health History:

Primary Care Doctor/Provider (if any):_____ phone number: (____)_____

Date of last full physical exam: _____, Results: normal other(_____)

Date of last blood work: _____, Results: normal other(_____)

Date of last PAP/ pelvic exam (females):_____, Results: _____

Date of last mammogram (females over 40): _____, Findings:_____

Date of last prostate exam (males):_____, Results:_____

Outpatient Procedures / Hospitalizations/ Major illnesses:

Type:	Date:	Treatment received:	Outcome / Results

Family History

_____

_____

_____

Lifestyle and Social Habits (how much and how often)

Tobacco: _____ Alcohol: _____ Recreational drugs: _____

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