FRESNO
HOLISTIC MEDICINE
A NATUROPATHIC WELLNESS CENTER

Setareh Tais, ND *Phone: 559-470-3435*

New Patient Extended Profile (Adult)

Please complete the following questionnaire as thoroughly as possible to aid your doctor(s) in their diagnosis and treatment. This will become a part of your confidential medical record and will not be released unless you have authorized us to do so. Please draw a line through or write "NA" in those sections, which do not apply. If you have more to say, please add those notes to a blank page and attach with the rest of your forms.

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

Address: _____ Phone: _____

Date of birth:_____ Age:_____ Gender: M/ F email:_____

How did you hear about us?_____

Present Health **Concerns** (in order of importance): Duration:

1. _____ _____
2. _____ _____
3. _____ _____

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

Vitamins/Herbal Medicines/Minerals that you are <u>now</u> taking:

Name / type prescribed	Reason for taking	Dose/day (mg/etc)	For how long	Who

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Drugs (prescription and over-the-counter, that you are now taking):

Name of drug doctor	Reason for drug	Dose (mg/etc)	For how long	Prescribing

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

Medical / Health History:

Are you seeing us as your family doctor? Yes / No

If No, who is your Primary Care Doctor/Provider (if any):_____

Clinic Name: _____Doctor's phone: (_____)_____

Doctors full address: _____

Other Current Health Provider(s):	Type:	Phone:
		(_____)_____
		(_____)_____
		(_____)_____

Date of last full physical exam: _____ Results: normal other:_____

Date of last blood test: _____Results: normal other_____

Date of last colonoscopy:_____Results: normal other_____

Date of last prostate exam (males):_____ Results: normal other: _____

Date of last PAP/ pelvic (females):_____ Results: normal other: _____

Last mammogram (females over 40): _____, Results: normal other:_____

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Major Illnesses/emotional or physical trauma/ accidents:

Type:	Date:	Treatment received:	Outcome:

Procedures / Hospitalizations (surgeries/ tonsillectomy, hysterectomy, appendectomy, special tests, broken bones, etc):

Type (of surgery/special test)	Date	Reason for procedure/ admission	Outcome / Results

Family History: (List information about your family members)

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

Allergies		Diabetes		Kidney disease	
Alcoholism		Cancer ( )			
Anemia		Cancer ( )		Obesity	
Arthritis(Rheumatoid)		Epilepsy		Stroke	
Arthritis(Osteo)		Heart Disease		Thyroid (low/ high)	
Auto Immune disease		High Blood Pressure		Osteoporosis	
Bleeding tendency		Cardiomyopathy		Other: ( )	
		Anxiety		Other: ( )	
		Depression		Other: ( )	

Father: Alive or Deceased (circle)? Age_____ **Mother**: Alive or Deceased (circle) Age_____

Children:
M=Male / F=Female

Name: _____Age:_____M/F
Name: _____Age:_____M/F
Name: _____Age:_____M/F
Name: _____Age:_____M/F
Name: _____Age:_____M/F
Name: _____Age:_____M/F

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

Single Married Divorced Widowed Significant other Name of spouse / partner: _____

Your Occupation: _____Do you like your job? _____Education:_____

What do you do at work? _____

_____

Are you sexually active? (circle one) **Yes / No** If yes, is it with (circle one): **male female both**

Do you or your partner(s) use any form of contraception? **Yes / No** If so, what type(s)?_____

Do you practice a regular Exercise Program?

What type of exercise?	Fow how long?	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diet history (include any liquid tea, coffee, etc., in description.):

Breakfast Yesterday	Lunch Yesterday	Dinner Yesterday	Snacks Yesterday
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How many glasses of **plain water** do you drink per day? _____

Do you practice any special diet restrictions? _____

Personal **Habits** (describe type, how much and how often):

Tobacco _____
Alcohol _____
Caffeine _____
Recreational drugs _____

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Sleep Habits:

How many hours/night:_____ Does sleep refresh you?_____ If not why?_____

What time do you usually go to sleep?_____What time do you usually wake up?_____

Do you have problems: falling asleep staying asleep waking up in the morning

If you wake up during the night, how often and at what times does this happen?_____

Energy level (average per week, circle one):

1 2 3 4 5 6 7 8 9 10
(lowest energy) (highest energy)

Stress level (average per week, circle one):

1 2 3 4 5 6 7 8 9 10
(lowest stress) (highest stress)

How do you cope with stress?_____

Who do you talk to about your problems?_____

What do for fun and how often?_____

Living Environment:

Who do you live with: _____

Pets: Dogs ____ Indoor /Outdoor; Cats ____ Indoor/ Outdoor; Other pet(s):_____

Spiritual Health: Do you attend church, mosque, or synagogue? Y N Occasional

Are there any special provisions regarding your beliefs the doctor should know about?

(e.g.: No blood products, etc.) _____

Are you sensitive to chemical smells? _____ Which ones? _____

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Eliminations (please complete):

	Bowel movement habits		Urine habits
Frequency: (how often) Twice/ day, every week…		Frequency: (how often per 24hour period)	
Color: (black, brown, yellow, green, white)		Color: (dark yellow, light yellow, green, colorless)	
Consistency: (hard, formed, soft, watery)		Character: (clear, cloudy, concentrated, dilute)	
Any mucus or blood on stool? (which)		Any blood or sediment? (which)	
Does stool pass easily?		Any pain, incontinence, other urinary symptoms?	

Digestion: Any stomach upset, bloating, burping, flatulence (gas), nausea, or rectal itching after food? (circle or specify):_____

Review of Systems Circle anything that you have experienced in the last 3 months

fatigue (affecting daily living)
dizziness (more than 5 seconds)

recent loss or change in vision
loss of hearing
frequent sinus infections
frequent sore throats

heart disease
chest pain
significant swelling of ankle
stroke
irregular heart beat

chronic bronchitis
tuberculosis
difficulty breathing
asthma

diarrhea
diarrhea (bloody)
constipation

stomach ulcers
nausea
vomiting

hepatitis
liver disease
kidney infection
kidney failure

female cramps
hot flashes
excessive menstrual flow
irregular menstrual cycles
prostate cancer
prostate enlargement
sex transmitted diseases

neck pain / stiffness
low back pain / stiffness
hot and swollen joints
bursitis
arthritis

skin problems
hair loss
brittle nails
nail fungus
fibrocystic breasts

persistent weakness
persistent numbness
persistent tingling
recurrent headaches
sleep problems

depression
anxiety

diabetes
thyroid problems

anemia
blood diseases
unusually severe bruising
allergies

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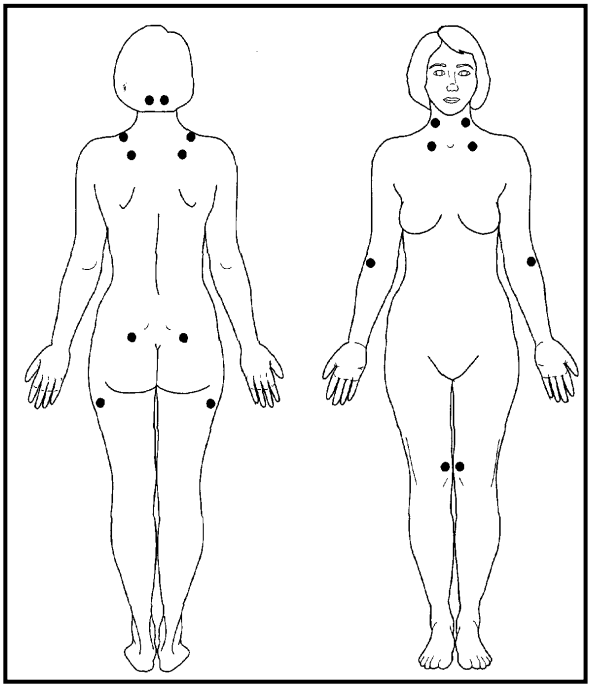
Do you have **chronic pain** or body discomfort?

Please indicate on the drawings the location and type of symptoms that you are experiencing.

A = Aching
B = Burning
SB = Stabbing
PN = Pins / Needles
N = Numbness
SPT = Spasm / Tight



Is there anything else I should know?

Please make sure to bring this form with you 15 minutes early to your scheduled appointment. Thank you for taking the time to share this important information with me. I look forward to helping you soon!