FRESNO
HOLISTIC MEDICINE
A NATUROPATHIC WELLNESS CENTER

Setareh Tais, ND *5305 N. Fresno Street #103; Fresno 93710* *Phone: 559-470-3435*

New Patient Extended Profile (Babies and Kids)

Please complete the following questionnaire as thoroughly as possible to aid your clinicians 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.

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

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

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

Mother's Name:_____ Father's Name:_____

Home Phone: (____)_____Work Phone:___(____)_____
mother/father/other

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

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

How did you hear about us?_____

Present Health Concerns (in order of importance): For how long?

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

Vitamins/Herbs/Supplements that you are now 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	Reason for drug	Dose (mg/etc)	For how long	Prescribing doctor

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

_____

Medical / Health History:

Primary Care Doctor/Provider (if any):_____Date last seen:_____

Reason for seeing:_____

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

Doctors full address: _____

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

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

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

Outpatient Procedures / Hospitalizations (surgeries/ special diagnostic studies):

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

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

Type:	Date:	Treatment received:	Outcome:

Family History (Using the following key, designate which family members have had the following. List type where parentheses are present):

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

condition	who	condition	who	condition	who
Allergies		Diabetes		Kidney disease	
Alcoholism		Cancer ( )		Mental disorder ( )	
Anemia		Cancer ( )		Obesity	
Arthritis(Rheumatoid)		Epilepsy		Stroke	
Arthritis(Osteo)		Heart Disease		Thyroid (low/ high)	
Auto Immune disease		High Blood Pressure		Other: ( )	
Bleeding tendency		High Cholesterol		Other: ( )	

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

Parents: Married Separated Divorced

Mother's Occupation:_____ Full Time: _____ Part Time:_____

Father's Occupation:_____ Full Time: _____ Part Time:_____

Guardian: _____Relationship:_____

Siblings: Name Age Health Problems

_____ _____ _____

_____ _____ _____

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_____ _____ _____

_____ _____ _____

Other's residing in the home and their relationship:_____

_____

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.) _____

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?_____

Stress:

How is stress coped with?_____

What do you do for fun and how often?_____

_____

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

How many glasses of **plain water** per day? _____ filtered tap distilled well water

Do you practice any special diet restrictions? _____

What was breakfast yesterday?_____

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What was lunch yesterday?_____

What was dinner yesterday?_____

List snacks you had yesterday:_____

Review of Systems (Health History) please check:

Past	Now		Past	Now	
____	____	Acne	____	____	Eczema
____	____	Allergies	____	____	Epilepsy/Seizure
____	____	Anemia	____	____	Fatigue
____	____	Asthma	____	____	Frequent Infections
____	____	Bed Wetting	____	____	Headaches
____	____	Birth Defects	____	____	Heart Murmur
____	____	Colic	____	____	High Fever
____	____	Croup	____	____	Hyperactivity
____	____	Constipation	____	____	Insomnia
____	____	Cough/Wheeze	____	____	Jaundice
____	____	Cradle Cap	____	____	Learning Disorder
____	____	Depression	____	____	Moodiness
____	____	Diarrhea	____	____	Stuffy Nose
____	____	Dizzy Spells	____	____	Thrush
____	____	Earaches	____	____	Vomiting Spells

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?	

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

_____

_____

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!