**Riverwalk Natural Health Clinic**
**Deborah A. Wiancek, ND**
**280 Main Street, Suite C-105**
**Edwards, CO 81632**

**Patient Profile**

Today's Date_____

Patient's Name_____ Age _____ Birth date_____

Address_____

Mother's Name_____ Father's Name_____

Mother/Father/Other Phone (Home)_____ (Work) _____

Health Insurance Co. _____E-mail_____
Group # _____ Insurance I.D.# _____
E-mail Address _____

**Person to be notified in case of Emergency:**

Name_____ Relationship _____
Address_____
Phone_____

**Present Health Concern:** Please list your current health concerns in their order of significance and indicate the concern that motivated you to come in today.

1. _____

2. _____

3. _____

4_____

**Medications:**

Aspirin _____
Tylenol_____
Antibiotics_____
Decongestants_____
Other_____

**Supplements:**

Vitamins and/or minerals:_____

Herbs:_____

**Allergies to medications or foods:**

Patient_____
Mother _____
Father _____

**Childhood Illnesses:**

| | | |
|---|---|---|
| _____ Chicken Pox | _____ Scarlet Fever | _____ Mononucleosis |
| _____ Measles | _____ Rheumatic Fever | _____ Ear Infections |
| _____ Mumps | _____ Strep Throat | _____ Tonsillitis |
| _____ Rubella | _____ Pneumonia | _____ Other_____ |

**Immunizations:** (Please list type, dates given and any adverse reactions)

_____
_____
_____
_____
_____

**Hospitalizations/Surgeries/Accidents/Serious Injuries & Illnesses:** (describe see incidents & give dates)

_____
_____
_____

**Family History**: (Identify all family members who have or have had any of the following)

| | |
|---|---|
| _____ Alcoholism | _____ Epilepsy |
| _____ Allergies | _____ Heart Disease |
| _____ Anemia | _____ Hearing Loss |
| _____ Arthritis | _____ High Blood Pressure |
| _____ Asthma | _____ Hypoglycemia |
| _____ Birth Defects | _____ Mental Illness |
| _____ Cancer | _____ Obesity |
| _____ Diabetes | _____ Stroke |
| _____ Eczema | _____ Thyroid Disorder |
| _____ Other | _____ Other |

**Infants/Child's/Adolescent's Health History:** (Please Check)

_____ Acne
_____ Allergies
_____ Anemia
_____ Asthma
_____ Bed Wetting
_____ Birth Defects
_____ Colic
_____ Constipation
_____ Cough/Wheezing
_____ Cradle Cap
_____ Depression
_____ Diarrhea
_____ Dizzy Spells
_____ Earaches
_____ Eczema
_____ Epilepsy/Seizures
_____ Fatigue
_____ Frequent Infections
_____ Headaches
_____ Heart Murmur
_____ High Fever
_____ Hyperactivity
_____ Insomnia
_____ Jaundice
_____ Learning Disorder
_____ Moodiness
_____ Stuffy Nose
_____ Thrush
_____ Vomiting Spells
_____ Other_____

**What is your infant's/child/adolescent's disposition?**

_____
_____
_____

**Prenatal/Birth/Feeding History:** (Mother's health during pregnancy with this infant/child/adolescent)

_____ Age
_____ Bleeding
_____ Nausea
_____ Illness
_____ Toxemia
_____ Alcohol Consumption
_____ Smoking
_____ Trauma/Injury
_____ Stress
_____ High Blood Pressure
_____ X-rays
_____ Medications
_____ Drugs
_____ Other

**Term:** Full _____ Premature _____ Late _____ Birth Weight_____

Was Pregnancy/Birth: Easy?_____
Difficult? _____

Place of Birth: Hospital_____ Home _____ Clinic _____ Other _____

**Feeding History:**

Breast Feed _____ How Long_____ Age Of Introduction of Cow's Milk _____
Formula Fed_____ How Long_____ Type of Formula_____
Food Allergy/Intolerance_____
Favorite Foods _____

**Sample Daily Diet:**(Choose a typical day & include food and liquids)

_____
_____
_____
_____
_____

**Previous pregnancies by natural mother and any complications:**

_____
_____

**Social History:**

Parents: Married _____ Separated _____ Divorced_____
Mother's Occupation_____ Full Time_____ Part Time _____
Father's Occupation _____ Full Time _____ Part Time _____
Other Guardian:_____ Relationship _____
Others residing at home_____
Daycare/Preschool/School_____
Where_____
How many hours each day? _____ Days of the week?_____

**Siblings**

| Name: | Age: | Health Problems |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |