WELLSPRING HEALTH

Name: _____ Date: _____

Age: _____ Date of Birth: _____

Are you right handed, left handed, or ambidextrous? _____

If not English-speaking, native language: _____

Referred by: _____

Reason for Referral: _____

PAST MEDICAL HISTORY

Please list all medical conditions for which you are currently receiving care from a doctor:

_____

_____

Allergies to Medications: _____

Current Medications (dose and frequency): _____

_____

Surgeries, with dates: _____

_____

Injuries, with dates (i.e. fractures, loss of consciousness): _____

_____

Blood Transfusions, with dates: _____

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SOCIAL HISTORY

Use of tobacco Packs per day: _____ Number of years: _____

Use of Alcohol Beverages per week: _____ Number of years: _____

Marital status: _____

Occupation: _____

Highest level of education: _____

Exposure to toxins (work/hobbies): _____

Birthplace: _____

FAMILY HISTORY

Mother: Living or deceased? Age: _____ Specific health conditions _____

Father: Living or deceased? Age: _____ Specific health conditions _____

Siblings: List from oldest to youngest.

1. Brother or Sister? Living or deceased? Age: _____ Health conditions: _____
2. Brother or Sister? Living or deceased? Age: _____ Health conditions: _____
3. Brother or Sister? Living or deceased? Age: _____ Health conditions: _____
4. Brother or Sister? Living or deceased? Age: _____ Health conditions: _____
5. Other Siblings? Living or deceased? Ages: _____ Health conditions: _____

WELLSPRING HEALTH

Name: _____ Date: _____

Children: List from oldest to youngest. Circle appropriate word.

1. Daughter or son? Living or deceased? Age: _____ Health conditions: _____
2. Daughter or son? Living or deceased? Age: _____ Health conditions: _____
3. Daughter or son? Living or deceased? Age: _____ Health conditions: _____

Height: Weight: Pain (scale of 1-10):

Are you currently experiencing any of the following symptoms?

Yes	No	
☐	☐	Blurred vision
☐	☐	Double Vision
☐	☐	Hearing Loss
☐	☐	Ringing in your ears
☐	☐	Chest pain
☐	☐	Abnormal heart beat
☐	☐	Shortness of breath
☐	☐	Skin rash
☐	☐	Swelling in your extremities
☐	☐	Joint Pain
☐	☐	Pain with urination
☐	☐	Frequency in urination
☐	☐	Abdominal pain
☐	☐	Blood in your stool
☐	☐	Weakness
☐	☐	Numbness
☐	☐	Fevers/Chills
☐	☐	Nausea/Vomiting
☐	☐	Unintentional weight loss
☐	☐	Other (please explain):

Patient's Signature: _____

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