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):
____

____
____

WELLSPRINGHEALTH

Surgeries, with dates: ____

____

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

____

Blood Transfusions, with dates: ____

Name: ____________________________________
Date: _________________

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): ____

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WELLSPRINGHEALTH

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: ________________

WELLSPRINGHEALTH

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: ______________
4. 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

WELLSPRINGHEALTH

Other (please explain):

Patient's Signature: ___________________________________

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