Wellspring Clinic
your source for natural medicine

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www.TheWellspringClinic.com

Patient Information

Name:____ Appointment Date:____________
First, MI, Last

Mailing Address:____
Street, City, Zip code

Phone____________ ____________ ____________ ____________
Home Work Cell email

☐ Remind me of appts by email

Occupation:__________________________ Employer:__________________________

Date of Birth:_______________________ Age:__________

Who may we thank for this referral?:____

Are you currently under the care of a health care practitioner?__________________________

Practitioner's Name:________________________________ Phone Number:____________

Please explain your health concerns:______________________________________

____

Please check any that apply:

____Recent injury	____Diabetes	____Chronic illness/health problems
____Allergies to scents/oils	____Recent illness	____Kidney problems
____Recent surgery	____Pregnancy	____Headaches
____High blood pressure	____Back problems	____Contagious diseases
____Blood clots	____Joint problems	____Circulation problems
____Varicose veins	____Chronic pain	____Phlebitis
____Wear contact lenses	____Contagious skin disorders	____Cancer or undiagnosed growths

Medications:____

____

What are the main sources of stress in your life?:__________________________________

Where in your body do you feel the effects of stress?:______________________________

What do you do for relaxation and/or exercise?____________________________________