WindSong Wellness Center
A place for Hope, Health and Harmony
1002 W. Drake, Ste 102, Fort Collins, CO 80526
(970) 530-0420

WELCOME!

Patient Information

Thank you for choosing WindSong Wellness Center for your natural health improvement. Please complete this form as thoroughly as possible. If you have any questions, do not hesitate to ask for assistance. Please use additional paper if needed to explain your health history. Please bring any lab work or copies of exam findings that you have had done in the last 6 months. Please Print.

Date_____

Name_____ DOB_____ Age_____ ❑ Male ❑ Female

Address_____ City_____ State_____ Zip_____

Phone (H) _____ Phone (W)_____ Other #_____

E-mail Address_____ Marital Status M S D W

Name of Spouse/Significant Other_____Children_____

If you are a minor, your parent's name's_____

Occupation_____ Employer_____

Person to contact in case of emergency_____ Phone#_____

Whom may we thank for referring you? How did you hear about us?_____

Please list the Top 5 health issues that you would like to resolve and what you are currently doing for them (if anything):

1. _____

2. _____

3._____

4. _____

5. _____

Please list all medications you are currently taking (prescribed or over-the-counter) and the condition for which it has been prescribed:_____

_____

Please list all surgeries, hospitalizations, illnesses and accidents:_____

_____

Please list all nutritional supplements, homeopathic or herbal remedies you are currently taking:_____

_____

_____

Please list all allergies (food, environmental, drugs, etc.): _____

_____

Please list all other health practitioners with whom you are currently seeing on a regular basis (please include your medical doctor, physical therapist, chiropractor, massage therapist, acupuncturist, etc):_____

_____

_____

Health History *Check any condition that you have had in the <u>past</u> or is <u>currently</u> a concern:*

- ❑ AIDS/HIV
- ❑ ADD/ADHD
- ❑ Alcoholism
- ❑ Allergies/ Shots
- ❑ Anorexia/Bulemia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lumps
- ❑ Broken Bones
- ❑ Bronchitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Chronic Fatigue
- ❑ Colitis/IBS
- ❑ Constipation
- ❑ Depression
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Digestive Pain/Issues
- ❑ Eating Disorder
- ❑ Eczema
- ❑ Emphysema
- ❑ Endometriosis
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Headaches
- ❑ Heartburn/Reflux
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hypoglycemia
- ❑ Infertility
- ❑ Joint Replacement
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Menstrual Problems
- ❑ Metal Toxicity
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nursing (presently)
- ❑ Osteoporosis/penia
- ❑ Pacemaker
- ❑ Pain – Neck, Back, Low Back, Pelvis, Limbs, Head
- ❑ Parasites
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ PMS
- ❑ Pneumonia
- ❑ Pregnant (presently)
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psoriasis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Skin Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors, Growths
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Other_____

_____

_____

Daily Habits

What type of exercise do you perform at least 3 days a week?_____

What do your daily work habits include? (sitting, standing, light labor, heavy labor, computer work, etc.)

_____

What are a typical breakfast, lunch, dinner and snack?_____

_____

How much coffee, tea, soda, (caffeine) do you consume on a daily basis?_____

How much alcohol do you consume on a weekly basis?_____

Do you smoke or chew tobacco? ❑ No ❑ Yes How much per day?_____ How many years?___

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Failure to disclose any pre-existing conditions as requested above may result in aggravation of symptoms. We are not responsible for aggravation of any pre-existing condition, which the patient has failed to fully disclose.

Please print your name_____

Signature _____ Date_____

Parent or Guardian Authorizing Treatment for Minor or Child_____