

Essential Healing Solutions
12 Old Boston Post Rd.
Old Saybrook, CT 06475

NAME _____ AGE _____

DATE OF BIRTH _____ TELEPHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ PHONE NUMBERS _____

TODAY'S DATE _____

Who referred you? _____

Main reason for visit: _____

Other concerns and health goals: _____

Major symptoms and or conditions: _____

When were you last seen by a physician? _____

Doctor's Name: _____

Address: _____

Telephone: _____

Diagnosis by your doctor: _____

Medications you are presently taking:

Supplements or over the counter drugs you are taking:

List any known allergies to food or drugs:

Family history of autoimmune disorder, cancer, diabetes, pervasive developmental disorder, MS or thyroid disorder: _____

Surgical history:

Thank-you for taking the time to fill this out
