Sheila Ring Reed, LCSW, LLC
18 Devonshire Dr
Waterford CT 06385

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