The Spring
Center for Natural Medicine

2416 South Lamar Blvd., Ste. B, Austin, TX 78704 • • • • • • • 512-445-7373 • • • • • • • www.thespringatx.com

NEW PATIENT INFORMATION

Name: ______________________________ Date: ______________

Address: ______________________________ Apt. #: __________
City: ____________________ State: ________ Zip: ______________
Shipping Address: ______________________________

Home/Cell: (_____)______________ Work: (_____)______________
Email: ______________________________

REFERRED BY: ______________________________

Occupation: ____________________ Employer: ____________________
Date of Birth: ____________ Age: _____ Sex: M/F Height: ______ Weight: ______

Overall health: (circle one) Excellent / Good / Fair / Poor Other: ______________

Chief complaint (reason you are here): (use separate sheet if more room needed):
____

Previous treatment for this complaint: ______________________________
____

Other complaints or problems:
____

Current medications/drugs being taken (use separate sheet if more room needed):
____

Are you currently under the care of a physician or other health care professional? (If yes, please list name and date of last visit.)
____

Nutritional supplements you are taking:
____

Do you smoke, drink coffee or alcohol? (If yes, please indicate how much.)
Cigarettes ______________ Coffee ______________ Alcohol ______________

For Office Use Only:

The Spring
Center for Natural Medicine

2416 South Lamar Blvd., Ste. B, Austin, TX 78704 • • • • • • • 512-445-7373 • • • • • • • www.thespringatx.com

NEW PATIENT INFORMATION

Name: ____ Date: ______________________

HISTORY:

List any major illnesses (with approximate dates):
____
____

List any surgery or operations (with approximate date)
____
____

Past accidents or injuries:
____

Marital Status: S M D W Name of Spouse: ____

Describe health of spouse: ____________________________________ Number of children: _______

Name of child	Age	Sex	Physical conditions or concerns
______________________	______	F / M	____
______________________	______	F / M	____
______________________	______	F / M	____

Any family history of serious illness (circle those which apply): Cancer / Diabetes / Heart /
Other: ____

Any household pets or other animals you or family members are in close contact with:

What can we do to make you happier?
____

Signature: ____ Date: __________________________

The Spring
Center for Natural Medicine
2416 South Lamar Blvd., Ste. B, Austin, TX 78704 • • • • • • • 512-445-7373 • • • • • • • www.thespringatx.com

NEW PATIENT INFORMATION

Name: ____ Date: ______________________

1. Chief Concerns:

2. Medications and/or nutritional supplements currently on:

The Spring
Center for Natural Medicine

2416 South Lamar Blvd., Ste. B, Austin, TX 78704 • • • • • • • 512-445-7373 • • • • • • • www.thespringatx.com

NEW PATIENT INFORMATION

3. Dietary intake for 2 days before appointment:

Breakfast:

Snacks:

Lunch:

Snacks:

Dinner:

Snacks:

Breakfast:

Snacks:

Lunch:

Snacks:

Dinner:

Snacks: