Sheila M. Ring, 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