VIRTUE MEDICINE P.C.

Clinics in Mind-Body Health

Studio for Ethics & Contemplative Arts

Parent/Guardian Name: _____

Mailing Address: _____

_____

(Home Phone)_____ (Work Phone) _____

(Cell Phone)_____ (Email) _____

I <u>prefer</u> for the Virtue Medicine/Dr. Wimberly to contact me at:

❑ Home Phone ❑Work Phone ❑ Cell Phone ❑ Email ❑ Specify: _____

Virtue Medicine uses a scheduling program that provides appointment confirmations by email.

❑ ***Check here if you <u>DO NOT</u> want appointment confirmations delivered to your email address*.**

Please provide the following information for your child

Child's Name: _____

Age: _____ Grade: _____

Extracurricular Activities: _____

_____

Child's Primary Care Physicians:

_____

_____

Other Health Care Providers for Child:

_____

_____

Past Medical History and Current Medical Problems (include the date/year of diagnosis)

Previous surgeries or injuries

Family medical history
(indicate the person's relationship to child and the diagnosis)

Caffeine? [ ] None [ ] Estimated 8-ounce caffeinated beverage per day ___

Tobacco? [ ] None [ ] Smoked cigarettes from age ____ to ____. ____ packs per day.
Check if you've used the following: [ ] Cigars [ ] Chewing Tobacco

Alcohol ? [ ] None [ ] Estimated drinks per week ____
Check if you've had the following alcohol complications: [ ] Black-outs [ ] Legal Problems [ ] Withdrawal Symptoms

Drugs? [ ] None [ ] Type(s) and history of use _____

Please list current medications, including supplements or vitamins:

Please list allergies or intolerances of medications, latex, dyes, foods, or other:

Describe your child's typical physical activities/exercise:

Describe your child's typical daily diet:

Do you have any concerns about violence or abuse in your current environments? [ ] Yes [ ] No
Have you been a victim of previous violence or abuse? [ ] Yes [ ] No

By signing this form, _____ of _____
(Parent/guardian) (Child)
Is granting permission for counseling services from Dr. Cynthia Wimberly.

Signature: _____ Date: _____