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. Wimbe ☐ Home Phone ☐ Work Phone ☐ Cell Ph	erly to contact me at: hone
_	n that provides appointment confirmations by email. tment confirmations delivered to your email address.
Please provide the following informati	on for your child
Child's Name:	
Age:	Grade:
Extracurricular Activities:	
Child's Primary Care Physicians:	
Other Health Care Providers for Child:	

Past Medical I	History and Current Medical Problem	S (include the date/year of diagnosis)
Previous surg	eries or injuries	Family medical history (indicate the person's relationship to child and the diagnosis)
Caffeine?	[] None [] Estimated 8-or	unce caffeinated beverage per day
Tobacco?		ttes from age to packs per day. Cigars [] Chewing Tobacco
Alcohol ?	Check if you've had the following alcohol complications: [] Black-outs [] Legal Problems [] Withdrawal Symptoms	
Drugs?	[] None [] Type(s) and his	story of use
Please list current medications, including supplements or vitamins:		
Please list allergies or intolerances of medications, latex, dyes, foods, or other:		
Describe your activities/exe	r child's typical physical rcise:	Describe your child's typical daily diet:
Do you have any concerns about violence or abuse in your current environments? [] Yes		
By signing this	s form,(Parent/guardian)	of(Child)
(Child) Is granting permission for counseling services from Dr. Cynthia Wimberly.		
Signature:		Date:

