Name: Date:

*Dear Patient:*

*Your appointment today is for 20 - 30 minutes. This is not a lot of time. Please note that appointments that run longer than 30 minutes will be charged the 30 – 45 minute appointment rate.* *To save time and money, please complete this form.*

**INSURANCE CHANGE:** Has your insurance changed since your last appointment here? □ No □ Yes: \_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL PROBLEMS**

Since your last appointment with your provider (i.e. Dr. Massoumi, Kim, Lauren or McKenzie) have you experienced a **NEW ONSET** or **WORSENING** of any of the problems listed below? (Please circle or check “yes/no” as appropriate)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **BODILY SYSTEM** | **PROBLEMS** (please circle) | **Yes** | **No** | **Please Explain** |
| Weight | Weight gain. Weight loss. |  |  |  |
| Eyes | Blurry or worsening vision. |  |  |  |
| Ears/Nose/Mouth/ Throat | Throat tightening. |  |  |  |
| Cardiovascular | Increased blood pressure. Chest pain. |  |  |  |
| Respiratory | Difficulty breathing. Shortness of breath |  |  |  |
| Gastrointestinal | Nausea. Vomiting. Constipation. Diarrhea |  |  |  |
| Genitourinary | Difficulty urinating |  |  |  |
| Muscular | Muscle twitches. Muscle tightness. Muscle spasms |  |  |  |
| Integumentary | Skin rashes. Hives. Itchy skin. Psoriasis. Eczema. Acne |  |  |  |
| Neurological | Headaches. Dizziness. Lightheadedness |  |  |  |
| Endocrine (Thyroid) | Feeling hotter or colder than those around you. |  |  |  |
| Endocrine (Females Only) | Change in menstrual cycle |  |  |  |
| Hematologic/Lymphatic | Easy bleeding or bruising. Swollen legs |  |  |  |
| Allergies/Immune | Recent cold, sinus infection, or other recent illness. |  |  |  |

* **Do you have paperwork (e.g. forms, applications, letters) for your provider to complete for you today?** □ No □ Yes (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **On a scale of 1 to 10 (10 being the happiest) how would you rate your mood:**

**TODAY?**

****1 2 3 4 5 6 7 8 9 10

**IN THE LAST ONE TO TWO WEEKS? (Circle the average or the range)**

1 2 3 4 5 6 7 8 9 10

**At WORST in the past two weeks?**

1 2 3 4 5 6 7 8 9 10

* **In the past few weeks, have you had any thoughts of wanting to end your life?** □ No □ Yes
* **How is your sleep?** □ Good □ Variable □ Poor

*(Continued on reverse)*

* **In the past week, how bad has your anxiety been?**

None Mild Moderate Severe

* **In the space below, write the TWO MOST IMPORTANT ISSUES (e.g. questions, problems, or symptoms) that you want to be sure to discuss with your provider today. (*Questions not listed here might not get answered today!)***

□ None 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Many people forget to take their medication(s) and/or supplement(s). What percentage of the time do you successfully remember to take your:**

Medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supplements? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*When you are done with this form, please* ***notify the front desk****. Thanks!!* ☺