NAME________________________________ **DATE**____________________________

CHIEF COMPLAINT: What symptoms are currently causing you the most distress/concern and/or are interfering the greatest with your day-to-day functioning?
(e.g., Insomnia, depression, anxiety)

1.________________________2.______________________3.________________________

Rate the severity of your current symptoms below **(circle)**:

Mildly disturbing					Moderate				Severely disturbing	
1	10	20	30	40	50	60	70	80	90	100

What life situations/stressors/losses/changes are contributing to symptoms?
Note: If you are not a new patient focus on changes since last visit.

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During the past month CIRCLE the degree of difficulty of each item:

	NO DIFFICULTY				VERY DIFFICULT
Routine daily activities: (getting dressed, having meals, shopping, cleaning)	1	2	3	4	5
Activities outside home: (work, school, other)	1	2	3	4	5
Social Activities: (visiting friends or family, social events, hobbies)	1	2	3	4	5

CURRENT MEDICATION LIST

Please list **everything** you are currently taking including prescription drugs, non-prescription drugs and herbal medications.
NOTE: Include meds from other doctors

MEDICATION and pill size in mgs	**DOSE TAKEN (in mgs.)** AM	Lunch	Supper	Bedtime	Total daily dose	Amount of time on current dose

Vitamins, minerals taken regularly:____

Medication side effects/interactions: Describe any new symptoms/problems that you have experienced since taking any of the medications listed. This includes anything changed or added that might cause side effects or interactions with other medications.
(e.g., sleep problems, drowsiness, dizziness, nausea, sexual problems, appetite/weight changes, nervousness, dry mouth, other)

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Circle your physical activity/exercise level: Sedentary Minimum Moderate High

Circle your diet/nutrition: Poor Fair Good Excellent

Do you use tobacco? Yes____No____What type?___________

If you answered cigarettes, how many per day?__________

Do you use “recreational” drugs? Yes____No____Which one(s)?_________________

Do you drink alcohol? Yes____No____How much per day?______________________

How many caffeinated beverages per day?__________

On average how much time do you spend outside in daylight, not counting in the car.

<30" 1/2-2 hrs. >2hrs.

List all physicians you are currently seeing besides me:

Name	Reason for treatment
______________________________	___________________________________
______________________________	___________________________________
______________________________	___________________________________

Circle how you feel you have been doing since your **last** visit to this office:

Much Worse Some Worse Same Some Better Much Better

Since your **last** visit, please list specific actions you have taken to help you to feel better, and/or to function better. This includes improvements physically, socially, work production, etc.

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