NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

8 Broad Street
Plattsburgh, NY 12901
Phone: (518) 825-1555 Fax: (518) 825-1550

INTAKE FORM

The treatment and counseling work we do is unique to you, just as it is to each one of our patients. Before we get started we need to collect some general information from you.

GENERAL INFORMATION

First Name | Last Name | Gender

Date of Birth (MM/DD/YYYY) | Social Security Number

Address

City | State | Zip Code

Main Phone | Other Phone

Email

EMERGENCY CONTACT

First Name | Last Name

Phone | Relationship

Do you authorize this person to discuss care or treatment with the office in the case of an emergency?

☐ **YES** ☐ **NO**

INSURANCE INFORMATION

PRIMARY INSURANCE | **Policy Holder**

Policy Holder D.O.B. (MM/DD/YYYY) | Relationship

Policy Holder Address

City | State | Zip Code

Policy Number | **Group Number**

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SECONDARY INSURANCE **Policy Holder**

Policy Holder D.O.B. (mm/dd/yyyy) Relationship

Policy Holder Address

City State Zip Code

Policy Number **Group Number**

PARENT/GUARDIAN INFORMATION (If applicable)

First Name Last Name

Phone Relationship

First Name Last Name

Phone Relationship

MENTAL HEALTH HISTORY/STATUS

What problems are you seeking help for?

Past Mental Health Treatment

Have you ever been hospitalized for psychiatric reasons? ☐ **YES** ☐ **NO**

If yes, when and where?

Have you ever had outpatient treatment by a psychiatrist or psychiatric provider (e.g. NP or PA)? ☐ **YES** ☐ **NO**

If yes, when and by whom?

Have you ever received counseling or psychotherapy in the past? ☐ **YES** ☐ **NO**

If yes, when and by whom?

NORTH COUNTRY BEHAVIORAL MEDICINE
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MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

DIRECTIONS: Please place a check mark in the box that describes your experience with any of the medications listed below.

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
ANTIDEPRESSANTS							
Amitriptyline	Elavil						
Bupropion	Wellbutrin, Wellbutrin SR, Wellbutrin XL						
Citalopram	Celexa						
Clomipramine	Anafranil						
Desipramine	Norpramin						
Desvenlafaxine	Pristiq						
Doxepin	Sinequan, Silenor						
Duloxetine	Cymbalta						
Escitalopram	Lexapro						
Fluoxetine	Prozac, Sarafem						
Fluvoxamine	Luvox, Luvox CR						
Imipramine	Tofranil						
Isocarboxazid	Marplan						
Levomilnacipran	Fetzima						
Milnacipran	Savella						
Mirtazapine	Remeron, Remeron SolTab						
Nefazodone	Serzone						
Nortriptyline	Pamelor						
Paroxetine	Paxil, Paxil CR						
Phenelzine	Nardil						
Selegiline Transdermal	Emsam						
Sertraline	Zoloft						
Tranylcypromine	Parnate						
Trazodone	Desyrel, Oleptro						
Venlafaxine	Effexor, Effexor XR						
Vilazodone	Viibryd						
Vortioxetine	Trintellix, Brintellix						
ANTIPSYCHOTICS “major tranquilizers”							
Aripiprazole	Abilify						
Asenapine	Saphris						
Brexpiprazole	Rexulti						
Cariprazine	Vraylar						
Chlorpromazine	Thorazine						
Clozapine	Clozaril, FazaClo, Versacloz						
Fluphenazine	Prolixin, Prolixin Decanoate						
Haloperidol	Haldol, Haldol Decanoate						
Iloperidone	Fanapt						

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MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Loxapine	Loxitane						
Lurasidone	Latuda						
Molindone	Moban						
Olanzapine	Zyprexa, Zyprexa Zydis, Zyprexa Relprevv						
Paliperidone	Invega, Invega Sustenna, Inrega Trinza						
Perphenazine	Trilafon						
Pimavanserin	Nuplazid						
Quetiapine	Seroquel, Seroquel XR						
Risperidone	Risperdal, Risperdal Consta, Risperdal M-Tab						
Thioridazine	Mellaril						
Thiothixene	Navane						
Trifluoperazine	Stelazine						
Ziprasidone	Geodon						
ANXIOLYTICS "anti-anxiety" "minor tranquilizers"							
Alprazolam	Xanax, Xanax XR						
Buspirone	BuSpar						
Chlordiazepoxide	Librium						
Clonazepam	Klonopin, Klonopin Wafers						
Clorazepate	Tranxene						
Diazepam	Valium						
Hydroxyzine	Vistaril, Atarax						
Lorazepam	Ativan						
Oxazepam	Serax						
ANTICHOLINESTERASE/ALZHEIMER'S AGENTS							
Donepezil	Aricept						
Galantamine	Razadyne						
Memantine	Namenda, Namenda XR						
Rivastigmine	Exelon						
Selegiline	Eldepryl						
Tacrine	Cognex						
ALCOHOL/DRUG/SMOKING CESSATION AGENTS							
Acamprosate	Campral						
Buprenorphine/ Naloxone	Suboxone, Bunavail, Zubsolv						
Bupropion	Zyban						
Disulfiram	Antabuse						
Methadone	Dolophine						
Naltrexone	ReVia, Vivitrol						

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MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Varenicline	Chantix						
MOOD STABILIZING AGENTS/AED's							
Carbamazepine	Tegretol, Tegretol XR						
Fluoxetine/Olanzapine	Symbyax						
Gabapentin	Neurontin						
Lamotrigine	Lamictal, Lamictal XR, Lamictal ODT						
Levetiracetam	Keppra, Keppra XR						
Lithium	Eskalith, Eskalith CR, Lithobid						
Oxcarbazepine	Trileptal						
Tiagabine	Gabitril						
Topiramate	Topamax						
Valproate	Depakene, Depakote, Depakote ER, Valproic Acid						
PSYCHOSTIMULANTS							
Amphetamine Salts	Adderall, Adderall XR						
Armodafinil, Pemoline	Nuvigil, Cylert						
Atomoxetine	Strattera						
Dexmethylphenidate	Focalin, Focalin XR						
Dextroamphetamine	Dexedrine, Dextrostat						
Lisdexamfetamine	Vyvanse						
Methylphenidate	Ritalin, Ritalin SR, Ritalin LA, Concerta, Metadate ER/CD, Methylin, QuilliChew ER, Quillivant XR						
Methylphenidate Transdermal	Daytrana						
Modafinil	Provigil						
SEDATIVE/HYPNOTICS							
Chloral Hydrate	Noctec						
Eszopiclone	Lunesta						
Flurazepam	Dalmane						
Ramelteon	Rozerem						
Suvorexant	Belsomra						
Temazepam	Restoril						
Triazolam	Halcion						
Zaleplon	Sonata						
Zolpidem	Ambien, Ambien CR, Intermezzo, Edluar						
OTHER							
Benztropine	Cogentin						

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MEDICATION QUESTIONNAIRE

Name:

Date: Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of Use	Adverse Reaction	Patient, Parent, Guardian or Physician/NPP Comments
Clonidine	Catapres, Kapvay						
Cyproheptadine	Periactin						
Diphenhydramine	Benadryl						
Guanfacine	Tenex, Intuniv						
Prazosin	Minipress						
Propranolol	Inderal						
Trihexyphenidyl	Artane						
HERBAL PREPARATIONS							

☐ I am unable or unwilling to complete this form. ☐ I have completed this form to the best of my ability.

Signature of Patient/Parent/Guardian: **Date:**

☐ Reviewed in person with the patient.

☐ Reviewed over the phone with the parent/guardian of the patient.

☐ Reviewed in person with the patient and / or parent/guardian of the patient.

Signature of Psychiatrist/NPP: **Date/Time:**

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GENERAL MEDICAL HISTORY

Primary Care Physician: _____

Please list any medical problems you may have below:

_____

_____

_____

_____

_____

Please list any serious medical procedures you have had in the past:

_____

_____

_____

_____

_____

Are you on any medications for any general medical problems you may have? ☐ **YES** ☐ **NO**

If yes, which ones? _____

Do you have any allergies to medications? ☐ **YES** ☐ **NO**

If yes, which ones? _____

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Alcohol, Drug, and Tobacco Use

Describe your use of alcohol:

Describe your use of recreational drugs:

Describe your use of tobacco:

Family Medical History

List any history of illness (mental or other) and substance abuse among blood relatives:

Mother's side **Father's side**

SOCIAL HISTORY

Birth place: Where did you grow up?

Did your parents get divorced as a child? ☐ **YES** ☐ **NO**

If so, how old were you when they separated?

Father's occupation growing up:

Mother's occupation growing up:

How many siblings do you have?

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Did you have any early development problems as a child?

Are you/were you a victim of any form of physical/sexual/emotional abuse?

Highest Level of Education:

Please list the last three jobs you have had below:

Current employment:

Are you currently in a romantic relationship? ☐ **YES** ☐ **NO** Duration: _____

Describe your relationship:

Spouse or partner's current occupation:

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Do you have any children? ☐ **YES** ☐ **NO** How many? _____

What are your children's names and ages?

What activities do you enjoy doing?

Have you ever been convicted of any crimes, served time, or been on probation? ☐ **YES** ☐ **NO**

Details:

Please list any additional notes that you think would be helpful for treatment below:

NORTH COUNTRY BEHAVIORAL MEDICINE
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CONSENT TO TREATMENT

First Name: Last Name:

You are about to take a very important step in your mental health treatment, and you are seeing a mental health professional. As your mental health provider, we will be entering into a protected relationship. Treatment might involve a multidimensional family approach. Due to this consent is needed for all those attending sessions.

We are treating you and we will do our best to accurately diagnose you and design a comprehensive treatment plan that will enable you to continue with a normal emotional development. This may include recommendations of therapy, or medications. This is all part of the service of a mental health professional. We will also work with your primary care physician to assure coordination of care.

_____**(Initial)**

You are our patient and have confidentially rights. Confidentiality does not apply under certain situations: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else. Except in these rare situations, your child has the right to keep particular topics confidential from even his/her guardian. Please respect this confidentiality. Again, if there is any concern of harm, suicide or other dangerous behavior, we will inform you.

If I require or think it is in your best interest to communicate with an outside source, I will request a release of information. To assure good therapeutic care, frequent appointments are required. Unless arranged otherwise, patients that have not been seen in 6 months may be considered inactive. A new evaluation will be required for any inactive patient to be seen.

_____**(Initial)**

I, _____(patient), do hereby seek and consent to take part in the treatment provided by North Country Behavioral Medicine PLLC. If I am attending group services I also understand and consent that confidentiality still applies and that North Country Behavioral Medicine PLLC is not liable for group members breaking confidentiality. I understand that developing a treatment plan with this provider and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this mental health professional.

_____**(Initial)**

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

I am aware that I may stop treatment with this mental health professional at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)
_____**(Initial)**

I am aware that if I attempt to contact my provider through phone, email, text, or any other form of communication over the Internet, my information may not be completely secure. In the event that my information is intercepted, North Country Behavioral Medicine is not responsible for the breach of patient privacy. Below are the approved contact means to leave messages on or respond to if contacted:

Phone: Email:

_____ **(Initial)**

_____	_____	_____
Patient Name (please print)	Patient Signature	Date

NORTH COUNTRY BEHAVIORAL MEDICINE
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LIFETIME INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

First Name: Last Name:

Release of Information: I, the subscriber named below, authorize North Country Behavioral Medicine PLLC and any providers working under North Country Behavioral Medicine PLLC examining or treating me to release any and all information pertaining to my treatment to any third party payer (such as my insurance company or a government agency) as needed to determine a claim for payment for such treatment and or diagnosis.

Physician Insurance Assignment: I, the below named subscriber, herby authorize payment directly to North Country Behavioral Medicine PLLC for my treatment at this office that is otherwise payable to me for their services as described.

Medicare/Medicaid – Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.

This assignment will remain in effect until revoked by me writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 90 days.

Patient Name (please print)

Patient/Guardian Signature Date

Insurance Company

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

HIPPA NOTICE/PRIVACY PRACTICES

First Name: Last Name:

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

North Country Behavioral Medicine PLLC, 8 Broad Street, Plattsburgh, NY 12901, (518) 825-1555

We understand the importance of privacy and are committed to maintaining the confidentiality of your information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please contact our office.

See front office for “HIPPA Detail” forms.

Patient Name (please print)

Patient/Guardian Signature Date

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

_____

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE — SIGNATURE — DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

APPOINTMENT CANCELLATION AGREEMENT

First Name: Last Name:

North Country Behavioral Medicine requires that all appointments be cancelled no later than **24 business hours before the appointment is scheduled (Monday through Friday 8:00 am to 5:00 pm).**

We understand there are occasionally circumstances beyond anyone's control causing appointments to be cancelled at the last minute. In an attempt to be fair, for well-established patients we allow for 3 late cancellations in a 12 month period. Upon the third late cancellation, a warning letter will be sent to the patient informing that any further late cancelled appointments **will result in a charge of $50**.

If an initial assessment is cancelled with notice of less than 24 business hours, this will result in a $100 charge. We do not waive charges for initial evaluations.

ALL NO SHOWS WILL RESULT IN A $100 FEE FOR INITIAL ASSESSMENTS AND $50 FEE FOR FOLLOW UP VISITS. REPEATED NO SHOWS MAY RESULT IN THE CLOSURE OF YOUR FILE.

If you are a Medicaid patient (including Managed Medicaid Plans or Medicare/Medicaid) you are not subject to the $50 fee, however after 3 late cancellations within 12 months, patients may be placed on same day status or their file with our clinic will be closed. If a new assessment is cancelled with less than 24 hours business hours' notice, your file may be closed. NO SHOWS FOR INITIAL ASSESSMENTS AND MORE THAN ONE NO SHOW FOR FOLLOW UPS OVER 12 MONTHS, WILL RESULT IN THE CLOSURE OF YOUR FILE.

While we do remind you of your appointment, it is your responsibility to call the office at (518) 825-1555, to cancel.

Printed Name

Signature Date

I understand that the office of North Country Behavioral Medicine PLLC will attempt to bill my insurance for services rendered, however ***if my insurance does not pay, for whatever reason, I am responsible for any remaining balance.*** This may include deductibles, copays, or out of pocket expenses.

My signature acknowledges:

- In the case of a Psychiatric Emergency I will call 911 or go to the nearest hospital
- 72 business hours is required for any prescription renewals.
- I will adhere to the guidelines above to the best of my ability.

Patient Name (please print)

Patient/Guardian Signature Date

NORTH COUNTRY BEHAVIORAL MEDICINE
SERVING THE COMMUNITY WITH COMPASSION

STATEMENT OF NON-DISCRIMINATION

This Practice does not differentiate or discriminate in the treatment of Persons on the basis of, to include, but not limited to: veteran status, race, ethnicity, mental or physical disability or medical condition, sexual orientation, gender, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, color, sex, age, religion, national origin, place of residence, health history, health status, handicap, source of payment or status as a Person.

Signature	Printed Name	Date

North Country Behavioral Medicine, PLLC

Patient Review of Systems Questionnaire

NAME:_____DATE: _____

Please check if you've had any of these symptoms within the last three weeks:

Constitutional
- ☐ Coldness
- ☐ Sweating
- ☐ Dry mouth
- ☐ Fatigue
- ☐ Fever

Eye, Ear, Nose, Mouth/Throat
- ☐ Blurred vision
- ☐ Corrective lenses: _____
- ☐ Double vision
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Frequent colds
- ☐ Frequent sore throats
- ☐ Difficulty swallowing

Cardiovascular
- ☐ Chest pain
- ☐ Leg/Arm swelling
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Palpitations/skipped beats
- ☐ Fast heart beat

Respiratory
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Wheezing

GI System
- ☐ Abdominal pain
- ☐ Anal problems
- ☐ Blood in stools/black stools
- ☐ Constipation/hard stools
- ☐ Diarrhea/unformed stools
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Genitourinary

Women:
- ☐ Vaginal discharge
- ☐ Menstrual cramps/pain
- ☐ Irregular periods
- ☐ STD

Men:
- ☐ STD
- ☐ Penile discharge
- ☐ Testicular swelling
- ☐ Testicular tenderness

Urinary
- ☐ Frequency
- ☐ Incontinence
- ☐ Recurrent infections
- ☐ Urgency
- ☐ Urethral discharge

Musculoskeletal
- ☐ Use of assistive device:_____
- ☐ Back pain
- ☐ Joint pain
- ☐ Stiffness
- ☐ Swelling
- ☐ Weakness

Skin/Hair/Nails
- ☐ Dry skin
- ☐ Hair loss
- ☐ Lacerations (cuts)
- ☐ Rashes
- ☐ Scars

Breast/Chest
- ☐ Breast feeding
- ☐ Nipple discharge
- ☐ Pain
- ☐ Swelling

Neurological
- ☐ Confusion
- ☐ Dizziness
- ☐ Headaches
- ☐ Head injury
- ☐ Memory problems
- ☐ Migraines
- ☐ Numbness
- ☐ Seizures
- ☐ Fainting
- ☐ Tingling
- ☐ Tremors

Endocrine
- ☐ Cold intolerance
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Excess urination
- ☐ Heat intolerance
- ☐ Weight gain
- ☐ Weight loss

Hematological
- ☐ Bruising
- ☐ Excessive bleeding
- ☐ Lumps/swelling

Allergies
- ☐ Drug
- ☐ Environment
- ☐ Seasonal
- ☐ Food

OTHER:

Patient Signature:

_____

Vital Signs (provider to enter):

BP: _____(Sitting)

PR: _____ **RR**: _____

O2: _____ **Temp**: _____

Height: _____**Weight:** _____