



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	



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?

CURRENT MENTAL HEALTH TREATMENT

Are you currently receiving mental health services? ☐ YES ☐ NO

If yes, where are you receiving services? _____

If changing services, why are you making this change? _____

Is someone (other than a parent for a minor child) helping you complete these forms? ☐ YES ☐ NO

If yes, what is their name and role? _____

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? _____

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						
Tranlycypromine	Parnate						
Trazodone	Desyrel, Oleptro						
Venlafaxine	Effexor, Effexor XR						
Vilazodone	Viibryd						
Vortioxetine	Trintellix, Brintellix						
ANTIPSYCHOTICS "major tranquilizers"							
Aripiprazole	Abilify						
Asenapine	Saphris						
Brexipiprazole	Rexulti						
Cariprazine	Vraylar						
Chlorpromazine	Thorazine						
Clozapine	Clozaril, FazaClo, Versacloz						
Fluphenazine	Prolixin, Prolixin Decanoate						
Haloperidol	Haldol, Haldol Decanoate						
Iloperidone	Fanapt						

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, Invega 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						

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							
Benzotropine	Cogentin						



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									
<input type="checkbox"/> I am unable or unwilling to complete this form.		<input type="checkbox"/> I have completed this form to the best of my ability.							
Signature of Patient/Parent/Guardian:						Date:			
<input type="checkbox"/> Reviewed in person with the patient.									
<input type="checkbox"/> Reviewed over the phone with the parent/guardian of the patient.									
<input type="checkbox"/> Reviewed in person with the patient and / or parent/guardian of the patient.									
Signature of Psychiatrist/NPP:						Date/Time:			



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?



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?



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:



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:



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 confidentiality 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)



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



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, hereby 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



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 _____



North Country Behavioral Medicine, PLLC
8 Broad Street
Plattsburgh, NY 12901

MRN

Name

DOB

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

BY SIGNING THIS FORM, YOU AUTHORIZE THE NORTH COUNTRY BEHAVIORAL MEDICINE, PLLC TO RELEASE OR OBTAIN YOUR HEALTH INFORMATION TO THE PARTIES LISTED IN SECTION C BELOW. PLEASE COMPLETE ALL SECTIONS. INCOMPLETE FORMS CAN PREVENT OR DELAY RELEASE.

Section A:

Patient Name: _____ Date of Birth: _____

Patient Address: _____ City: _____

State & Zip Code: _____ Phone Number: _____

Section B: Reason for Release of Information:

<input type="checkbox"/> Medical Care	<input type="checkbox"/> Personal Records	<input type="checkbox"/> Insurance/Payment	<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> School:
<input type="checkbox"/> Attorney/Legal Proceedings	<input type="checkbox"/> Provider Transfer	<input type="checkbox"/> Disability	<input type="checkbox"/> Other:	

Section C: Party to Receive or Obtain Information From:

- ☐ Release a copy of my protected health information (PHI) to:
- ☐ Obtain a copy of my PHI from:
- ☐ I decline to have PHI shared to or from North Country Behavioral Medicine, PLLC (except as allowed by HIPAA regulation)

Name: _____	
Address: _____	
Phone Number: _____	Fax Number: _____
Delivery Method : <input type="checkbox"/> Mail <input type="checkbox"/> Fax	
<input type="checkbox"/> E-mail address: _____ (only for patients, patient guardian(s), or next of kin for deceased patients).	
<input type="checkbox"/> Other: _____	
Please note that if the request is for an unencrypted electronic delivery method, it may not be secure. The requester acknowledges and accepts risk associated with unencrypted electronic transmission. It is the recipient's responsibility to protect the information once received.	

Section D: Description of the Information to be released/obtained:

The date of service and type(s) of information to be released or obtained are as follows:

The records to be released will cover the time period from _____ to _____

Records from a specific Provider/Clinic: _____

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Emergency Dept. Notes | <input type="checkbox"/> Cardiology Testing Reports | <input type="checkbox"/> Billing |
| <input type="checkbox"/> Inpatient Notes | <input type="checkbox"/> Laboratory/Pathology Reports | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Office or Clinic Notes | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Radiology Images | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Consults | | | |

☐ Other: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Section E:

For certain sensitive information, you must initial in the box below for the information to be included in your release.

SENSITIVE HEALTH INFORMATION This form authorizes UVM Medical Center to release the following types of information, **ONLY IF** you place your initials in the space provided:

_____ Mental Health Records (including Psychotherapy) _____ Confidential HIV/AIDS Information
_____ Sexually Transmitted disease (STI) records _____ Genetic Testing Results
_____ Substance, Drug, Alcohol Use Disorder Records from a 42 CFR Part 2 program

- Certain alcohol/drug treatment information from a "Part 2 Program" must be accompanied by the required statement regarding prohibition of re-disclosure. (42 CFR Part 2)
- For New York sites: Confidential HIV/AIDS information must be accompanied by the required statements regarding prohibition of disclosure when required by law. Information from certain mental health clinical records may be released pursuant to this authorization to the parties identified, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

I understand and agree that:

- I may be charged a fee for copies in accordance with state and federal law. The fee schedule is available by contacting Health Information Management by **Phone: (518) 825-1555 or Fax: (518) 825-1550**.
- I can revoke (cancel) this authorization at any time by submitting my request in writing to the entity to whom I submitted this authorization form. My revocation will not apply to information that has already been released in reliance upon this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected under federal and state law, unless specific re-disclosure laws apply.
- Signing this form is voluntary. I do not need to sign this form to receive health care services from North Country Behavioral Medicine, PLLC.
- **This authorization will expire on _____.** If I do not specify an expiration date, this authorization will expire one (1) year from the date signed.

When the patient is a minor or is not competent to provide authorization, the signature of a parent, legal guardian or other legal representative is required. If the patient is between the ages of 12-17, the patient will need to authorize the release of records for some services. Documentation of a legal representative's authority may be required to process this form.

Signature of Patient

Date

Time

Signature of Parent or Legal Representative

Date

Time

Print Name

Relationship (if signed by Parent/Legal Representative)

FOR OFFICE USE ONLY

I have authenticated the identity of the person named in this authorization form via ☐ Photo ID ☐ Other

Employee Signature

Date Received

Date Completed



CLINIC POLICY AGREEMENT

First Name: _____

Last Name: _____

ACKNOWLEDGEMENT OF CLINIC ATTENDANCE POLICY:

INITIAL ____ I understand that 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, excluding holidays).**

INITIAL ____ I understand that ***if I no-show or cancel an initial evaluation with our clinic with less than 24 business hours' notice, my file will be closed.***

INITIAL ____ I understand that I will be allowed 3 (three) late cancellations in a 12 month period. If this number is exceeded, ***I understand that my file will be closed.***

INITIAL ____ I understand that I will be allowed 2 (two) no-shows in a 12 month period. ***If this number is exceeded, I understand that my file will be closed.***

INITIAL ____ Notwithstanding the above, I understand that I will be allowed a **combined total** of 1 (one) no-shows and 2 (two) late cancellations in a 12 month period. ***If this number is exceeded, I understand that my file will be closed.***

INITIAL ____ I understand that ***if I have commercial insurance I will be charged \$75 for any no-show appointment.***

INITIAL ____ I understand that it is ***my responsibility to call the office at (518) 825-1555, or via our appointment reminder system, to cancel any appointment.***

By signing below I acknowledge that I have read, understand and will abide by the above policies and that if I do not, my file with North Country Behavioral Medicine will be closed.

Printed Name _____

Signature _____

Date _____

Additionally, I understand that the office of North Country Behavioral Medicine PLLC will attempt to bill my insurance, 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 _____



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 <ul style="list-style-type: none"><input type="checkbox"/> Coldness<input type="checkbox"/> Sweating<input type="checkbox"/> Dry mouth<input type="checkbox"/> Fatigue<input type="checkbox"/> Fever Eye, Ear, Nose, Mouth/Throat <ul style="list-style-type: none"><input type="checkbox"/> Blurred vision<input type="checkbox"/> Corrective lenses: _____<input type="checkbox"/> Double vision<input type="checkbox"/> Ringing in ears<input type="checkbox"/> Hearing loss<input type="checkbox"/> Frequent colds<input type="checkbox"/> Frequent sore throats<input type="checkbox"/> Difficulty swallowing Cardiovascular <ul style="list-style-type: none"><input type="checkbox"/> Chest pain<input type="checkbox"/> Leg/Arm swelling<input type="checkbox"/> High blood pressure<input type="checkbox"/> Low blood pressure<input type="checkbox"/> Palpitations/skipped beats<input type="checkbox"/> Fast heart beat Respiratory <ul style="list-style-type: none"><input type="checkbox"/> Coughing<input type="checkbox"/> Shortness of breath<input type="checkbox"/> Wheezing GI System <ul style="list-style-type: none"><input type="checkbox"/> Abdominal pain<input type="checkbox"/> Anal problems<input type="checkbox"/> Blood in stools/black stools<input type="checkbox"/> Constipation/hard stools<input type="checkbox"/> Diarrhea/unformed stools<input type="checkbox"/> Heartburn<input type="checkbox"/> Nausea<input type="checkbox"/> Vomiting	Genitourinary <p>Women:</p> <ul style="list-style-type: none"><input type="checkbox"/> Vaginal discharge<input type="checkbox"/> Menstrual cramps/pain<input type="checkbox"/> Irregular periods<input type="checkbox"/> STD <p>Men:</p> <ul style="list-style-type: none"><input type="checkbox"/> STD<input type="checkbox"/> Penile discharge<input type="checkbox"/> Testicular swelling<input type="checkbox"/> Testicular tenderness Urinary <ul style="list-style-type: none"><input type="checkbox"/> Frequency<input type="checkbox"/> Incontinence<input type="checkbox"/> Recurrent infections<input type="checkbox"/> Urgency<input type="checkbox"/> Urethral discharge Musculoskeletal <ul style="list-style-type: none"><input type="checkbox"/> Use of assistive device: _____<input type="checkbox"/> Back pain<input type="checkbox"/> Joint pain<input type="checkbox"/> Stiffness<input type="checkbox"/> Swelling<input type="checkbox"/> Weakness Skin/Hair/Nails <ul style="list-style-type: none"><input type="checkbox"/> Dry skin<input type="checkbox"/> Hair loss<input type="checkbox"/> Lacerations (cuts)<input type="checkbox"/> Rashes<input type="checkbox"/> Scars Breast/Chest <ul style="list-style-type: none"><input type="checkbox"/> Breast feeding<input type="checkbox"/> Nipple discharge<input type="checkbox"/> Pain<input type="checkbox"/> Swelling	Neurological <ul style="list-style-type: none"><input type="checkbox"/> Confusion<input type="checkbox"/> Dizziness<input type="checkbox"/> Headaches<input type="checkbox"/> Head injury<input type="checkbox"/> Memory problems<input type="checkbox"/> Migraines<input type="checkbox"/> Numbness<input type="checkbox"/> Seizures<input type="checkbox"/> Fainting<input type="checkbox"/> Tingling<input type="checkbox"/> Tremors Endocrine <ul style="list-style-type: none"><input type="checkbox"/> Cold intolerance<input type="checkbox"/> Excessive hunger<input type="checkbox"/> Excessive thirst<input type="checkbox"/> Excess urination<input type="checkbox"/> Heat intolerance<input type="checkbox"/> Weight gain<input type="checkbox"/> Weight loss Hematological <ul style="list-style-type: none"><input type="checkbox"/> Bruising<input type="checkbox"/> Excessive bleeding<input type="checkbox"/> Lumps/swelling Allergies <ul style="list-style-type: none"><input type="checkbox"/> Drug<input type="checkbox"/> Environment<input type="checkbox"/> Seasonal<input type="checkbox"/> Food OTHER:
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Patient Signature:

Vital Signs (provider to enter):

BP: _____ (Sitting)

PR: _____ **RR:** _____

O2: _____ **Temp:** _____

Height: _____ **Weight:** _____