Screening Paperwork

Name:__________________________________ **Date of Birth:** _____________

Who initiated this appointment?

- Myself
- Another Physician/clinician:__________
- Family Member:___________________
- Other:____________________________

Referred by: _________________________

Do you experience any of the following on a regular basis?

- Fatigue
- Loss of appetite
- Lack of desire
- Depression
- Anxiety
- Panic attacks
- Chronic pain/inflammation
- Shortness of breath
- Skin dryness/irritation
- Mood swings/irritability
- Nausea/vomiting
- Diarrhea/constipation
- Headaches/migraines
- Dizziness
- Insomnia
- Other:____________

What services and/or treatment options are you interested in?

- Nutrition Counseling
- Exercise Planning
- ADD/ADHD Skills
- Time Management
- Weight Loss
- Sleep
- Lifestyle Management of Chronic Disease
- Supplements/Herbs/ Medical Foods
- Hormone Optimization
- Mental Health Physical
- Psychiatric Evaluation and Treatment
- Brain Imaging
- Cancer Screening/ Recovery
- Genetic Testing
  - Health and Wellness
  - Skin Care/Health
  - Mental Health
  - Medication Insights

Are you having or have you had any thoughts/plans to harm yourself or anyone else? YES NO
If yes please describe in more detail: ____
____

Have you ever attempted suicide? YES NO
If yes, describe event and date.____

Patient Name:________________________________DOB:___________

Current Treatment:
Primary Care doctor/clinic:______________________________ Phone #:_______________________
Date of last physical:___________________________________ Fax #:_________________________
Psychiatrist:____ Phone #:_______________________
Fax #:_________________________
Other specialists (specify condition and contact information):________________________________
____
Alternative providers (chiropractor, acupuncture, etc…)______________________________________
____
Therapists:____
Support groups (AA, Al-anon, etc…)____
Describe your current spiritual practice:____
Have you had any blood work drawn in the last year? YES NO

Current Medications: ____

Current Supplements:____

Level of Impairment:
Please answer on a scale of 1-10 (1 being mild/no or minimal impairment and 10 being severe/substantial impairment)

How does this affect your relationships (family, friends, supervisors, co-workers, etc…)
1 2 3 4 5 6 7 8 9 10
Explain if necessary:____ How does this affect your job/school (ie. Skipping class/work, productivity/grades, etc…)
1 2 3 4 5 6 7 8 9 10
Explain if necessary:____
How does this affect your health/self care?
1 2 3 4 5 6 7 8 9 10
Explain if necessary:____

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Schedule with____________________________ within__________________________

Releases Needed: ____
____

LOI Total: ____________ LOD: __________
LOI Average: __________
Level of Acuity (LOD+LOI): __________
Notes:____
____

Reviewed by:

__________________________________ ________________
Name Date