Lifetime Psychiatry

Welcome to our practice:

Our dedicated specialty medical providers and staff are committed to providing the highest quality medical care for our patients. Set forth below are guidelines for your participation in treatment. Your treatment is very important to us, we ask that you review the following to ensure that you receive the best care possible and that your visit exceeds your expectations. Please read the following carefully and ask the front desk staff if you have any questions.

EMERGENCIES: The office voicemail lists the emergency contact number for your provider. After normal office hours, you may reach the contact list by dialing 636-477-6464. You will also find this emergency contact number on your appointment card**. Please note that this number is for emergency situations only.** Refills, appointments, and non-emergency situations will not be handled after hours. SSM DePaul Behavioral Health Urgent Care is an option for after hour urgent treatment 314-344-7200.

OFFICE HOURS: The office is open Monday & Wednesday 9a -5p, Tuesday & Thursday 8:30a-4p, the office is **CLOSED** on Friday. Office phones are answered by our knowledgeable staff. At times, you may be required to leave a message as we experience a high volume of calls during office hours. We check the voicemail frequently to ensure that all messages are answered promptly by the staff. Please note that your provider may need to be contacted in order for the staff to respond to your request.

APPOINTMENTS: In person appointments are preferred . Telehealth appointments are offered at your provider's request. Telehealth patients must be in the state of Missouri for their scheduled telehealth appointment. Upon being seen, you will be given a follow-up appointment. It is very important that you keep this appointment. Should you need to reschedule your appointment, please notify the office as soon as possible so that we may make you another appointment as close to your recommended follow-up visit as possible. Patients arriving more than 10 minutes late may be asked to reschedule.

Patients who are minors will not be seen without his/her legal guardian present without prior consent from the provider.

We kindly ask that you limit the people that accompany you to your appointment. Our office is very busy, and space is limited. Please note that we cannot have children waiting in our waiting area without the supervision of a parent, guardian, or caretaker.

Medication refills may not be approved for patients who do not keep their scheduled appointment and/or do not have a scheduled appointment.

TREATMENT: At times you may experience situational difficulties or require a medication adjustment before your scheduled appointment. Please contact the office during office hours at 636-477-6464, for an earlier appointment. Although appointments are preferred, in some cases your situation may be handled by leaving a message with the receptionist. Please allow time for the receptionist to review your call with your physician and contact you with his/her recommendations.

MEDICATION: Our office uses an electronic prescription system. In most cases you will receive enough medication with refills until your next appointment. For medication refills prior to your scheduled appointment, please contact your pharmacy and provide them with your prescription number along with any changes in your medication since your last refill. Some controlled medications may require you to request a refill from the office staff. Medication can be refilled no more than 5 days early.

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MEDICATION PRIOR AUTHORIZATION: The insurance company that provides you with prescription coverage may request that prior authorization be completed on a specific medication before agreeing to insurance coverage for the medication. Once you have turned in your prescription to the pharmacy, your pharmacist will submit the charges for the medication to your insurance company. Your insurance company will let your pharmacist know if prior authorization is needed for the medication. Then the pharmacist will notify our office that prior authorization is required for your insurance to cover the cost of the medication. The pharmacist will provide our office with the information needed to initiate the prior authorization process. Your provider will review the request for prior authorization and either recommend a different medication or request the office to proceed with the prior authorization. Prior authorizations typically take 3-5 days to fully process. An approval of coverage is not guaranteed.

If the medication requiring a prior authorization is a current medication that you have been taking and you are out of medication, please discuss your options with your pharmacy for a 3–5-day supply. Please contact your insurance company with questions regarding insurance coverage of your medication.

CHARGES: We will gladly file your insurance claim for you, we do this as a courtesy, please provide us with your insurance card and information. Any portion of the professional fee that is not covered by your insurance company is your responsibility. We cannot accept responsibility for collecting your insurance benefits or for negotiating a settlement on a disputed claim. Any portion of the bill the insurance company has not paid within 45 days or has been denied will be the patient's responsibility. Payment of copays, coinsurances and balances are required at the time of your visit. It is your responsibility to notify our office of any insurance changes. You may reach the billing department by calling 1-877-589-7851.

CONFIRMATION, CANCELLATION OR NON-KEPT APPOINTMENTS: Our automated confirmation system will send a text or email 2 days prior to your appointment with a courtesy reminder of your scheduled appointment. Please reply "YES" to confirm your appointment. We ask that you kindly give 24 HOUR notice, by calling the office, if you are unable to keep your scheduled appointment. We understand short notice emergencies if you cannot make your appointment, please contact your office at 636-477-6464 as soon as possible to reschedule. Patients who DO NOT GIVE 24-HOUR NOTICE of cancellation will be CHARGED 75.00. Insurance companies will not pay for these types of charges; therefore, payment is due by you. After a patient has canceled or not attended three appointments without 24-hour notice, the office will no longer schedule appointments or refill medication(s) for the patient.

Please notify the receptionist if you do not wish to receive the automated confirmation text or email. Please note, if you opt out of automated text and E-mail reminders you will not receive an appointment reminder.

Thank you for allowing our office to participate in your care. Please do not hesitate to contact the office should you have any questions regarding your Welcome paperwork.

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Please sign below to indicate that you have reviewed, agree and are aware of the office guidelines. I authorize my insurance carrier to issue benefits of my plan to this office. I authorize the release of any information necessary to process my claims for service.

Respectfully,
Lifetime Psychiatry, LLC
Equilibrium Mental Health Services

_____

Patient Signature **Date**

_____

Patient Name

_____

Relationship to Patient

Lifetime Psychiatry

DIRECTIONS TO 5700 MEXICO ROAD, SUITE 8, ST PETERS, MO 63376

Suite 8 is located at the center of the building.

Coming from the East

- Take I-70 West to Cave Springs Blvd exit 225
- Turn left on Cave Springs Blvd
- Turn right on Mexico Road
- 5700 Mexico Road is located on the right, just past the Recplex, across from City Center Park

Coming from the West

- Take I-70 East to S Service Rd/Veterans Memorial Pkwy exit 222 B
- Turn right onto right onto Spencer Loop South
- Turn left onto Spencer Road
- Turn left onto Mexico Road
- 5700 Mexico Road is located on the left, just past the stop light

Coming from Highway 364

- Take Hwy 364 East
- Proceed Mid Rivers Mall Drive
- Turn left on Mid Rivers Mall Drive
- Proceed 3.8 miles to Mexico Road
- Turn right on Mexico Road
- 5700 Mexico Road is located on the left, just past the stop light

Lifetime Psychiatry

HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, among other reasons, to:

* Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

* Obtain payment from designated third-party payers.

* Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by Lifetime Psychiatry, LLC & Equilibrium Mental Health Services of its Notice of Privacy Practices. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. The Notice of Privacy Practices is posted on our website at Lifetimepsyciatry.com, at all office locations and is available in a handout form at the receptionist desk. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations.

I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

_____ I agree to be contacted by office staff or automated services via my home and cell phone number as well as via text and email.

_____Office staff may speak with the following person (s) regarding my appointments and accounts:

Name: _____Relationship_____

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has acted relying on this consent.

_____

Patient's Name **Date of Birth (MM/DD/YYYY)**

_____

Signed (Patient or Legal Representative for Patient) **Date**

_____

Legal Representative's Relationship to Patient

Lifetime Psychiatry

CONSENT FORM FOR ELECTRONIC PRESCRIBE PROGRAM

Electronic Prescribing is the method for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The Electronic Prescribing Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Lifetime Psychiatry, LLC & Equilibrium Mental Health Services, as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS.
As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Consent
By signing this consent form, you are agreeing that your provider at Advent Medical Group may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not influence any actions taken prior to receiving the revocation.

By signing this consent form, you agree that Lifetime Psychiatry, LLC & Equilibrium Mental Health Services can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to Lifetime Psychiatry, LLC & Equilibrium Mental Health Services to prescribe medication to me using the e-Prescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

Print Patient Name _____ **Patient DOB**_____

Signature of Patient or Guardian _____ **Date**_____

Relationship to Patient _____

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SIGNATURE ON FILE

I authorize the use of this form on all my insurance submissions.
I authorize the release of information to all my Insurance Companies, Managed Care Companies, and PCP, including substance abuse/dependency information, if applicable.
I authorize Lifetime Psychiatry, LLC and/or Equilibrium Mental Health Services, LLC as well as the staff to act as my agent in obtaining payment from the Insurance Companies.
I authorize payment directly to a provider of Lifetime Psychiatry, LLC and/or Equilibrium Mental Health Services LLC.
I authorized information regarding my care to be released to my Residential Caregiver/ POA/ or others responsible for my well being.
I permit a copy of this authorization to be used in place of the original.
I understand that this consent form will be valid and remain in effect until revoked in writing and delivered to Lifetime Psychiatry, LLC and/or Equilibrium Mental Health Services, LLC.
I understand that I am responsible for the charges for services rendered.

_____

Print patient's name

_____

Patient's/Insured/Authorized signature **Date**

AUTHORIZATION FOR TREATMENT

I authorized treatment for _____to be performed by a provider of Lifetime Psychiatry, LLC and/or Equilibrium Mental Health Services, LLC. I consent to treatment in-person and or via telehealth.

Patient's or Authorized signature
_____Date_____

SIGNATURE ON FILE
MEDICARE PATIENTS ONLY

Name of patient: _____HIC#_____

Medigap Insurer_____Policy#_____

I request that the payment of authorized Medicare benefits be made either to me or on my behalf to a provider of Lifetime Psychiatry, LLC and/or Equilibrium Mental Health Services, LLC for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.
I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

Patient's/Insured/Authorized signature _____Date_____

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New Patient Registration Form

PATIENT INFORMATION

Name (Last, First, Middle): _____ DOB: _____
Gender at birth: _____ Gender Identified as: _____
Address: _____ _____ City: _____ State: _____ Zip: _____
SSN: ___-___-____ Preferred Number: (___)-____-_____ Cell Phone: (___)-____-_____
Would you like to receive an appointment reminder text? Yes: _____ No: _____
Email Address: _____ Employer: _____ Work Phone:(____)-____-_____
Marital Status: _____Married _____ Single_____ Divorced _____Widowed.
Preferred Language: _____ Ethnicity: _____ Race: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Address: _____
Cell/Home Phone: (____)-_____-_____ Work Phone: (____)-_____-_____
Permission to contact: Yes_____ No _____

RESPONSIBLE PARTY

Complete if different from the patient or under the age of 18.

Full Name: _____ DOB: _____ Gender: _____ SSN: ____-____-_____
Address: _____ City: _____ State: _____ Zip: _____
Relationship to patient: _____ Home Phone:(____)-_____-_____ Cell Phone: (____)-_____-_____
Employer: _____ Work Phone: (____)-_____-_____

INSURANCE

PRIMARY INSURANCE

Plan Name: _____ I.D. Number: _____ Group Number: _____
Plan Address: _____ Effective Date: _____ Copay $: _____
Policy Holder: _____ Gender: _____ Policy Holders SSN: ____-____-_____
Policy Holders Date of Birth: _____/_____/_____ Relationship to patient: _____

SECONDARY INSURANCE

Plan Name: _____ I.D. Number: _____ Group Number: _____
Plan Address: _____ Effective Date: _____ Copay $: _____
Policy Holder: _____ Gender: _____ Policy Holders SSN: ____-____-_____
Policy Holders Date of Birth: _____/_____/_____ Relationship to patient: _____

TERTIARY INSURANCE

Plan Name: _____ I.D. Number: _____ Group Number: _____
Plan Address: _____ Effective Date: _____ Copay $: _____
Policy Holder: _____ Gender: _____ Policy Holders SSN: ____-____-_____
Policy Holders Date of Birth: _____/_____/_____ Relationship to patient: _____

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Name: _____ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____ Therapist/Counselor: _____

Previous Psychiatrist/Therapist: _____

Pharmacy: Name: _____
Address: _____
Phone: _____ Fax: _____

I give Consent to retrieve medication fill history with all pharmacies _____
Initials

Medication Allergies: **____ No ____Yes** *(Please list below)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Current Medications: *(Prescribed and Over the counter)*

- List Attached

Medication	*Dose*	*Directions*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Psychiatric Medications: _____
_____
_____

Previous Psychiatric In-patient Admissions: _____YES _____NO (*Please list below)*
_____
_____
_____

Past Medical Diagnoses/Medical History: _____
_____
_____

Past Surgical History: _____
_____
_____

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Family Psychiatric History (Please check all that apply)

	Mother	Father	Sibling	Aunt/Uncle	Grandparent	Children
Major Depression	❑	❑	❑	❑	❑	❑
Manic/Bipolar Disorder	❑	❑	❑	❑	❑	❑
Anxiety Disorder	❑	❑	❑	❑	❑	❑
Attention Deficit Disorder	❑	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑	❑
Suicide	❑	❑	❑	❑	❑	❑
Alcohol/Drug History	❑	❑	❑	❑	❑	❑
Psychiatric Hospitalizations	❑	❑	❑	❑	❑	❑

Other:

Social History Under 16 Years (Please check all that apply)

Living with: ❑ Both Parents ❑ Mom ❑ Dad ❑ Guardian ❑ Other Adult

Siblings: ❑ Yes ❑ No

Developmental milestones: ❑ Reached ❑ Not Reached

Education History: ❑ Provided at home ❑ At Grade Level ❑ Below Grade Level

Interest/Activities: ❑ Sports ❑ Music ❑ Reading ❑ Church ❑ Other:

Identified Stressors: ❑ Medical Issues ❑ Family Conflict ❑ School ❑ Lifestyle changes ❑ Recent Death

Legal History: ❑ No ❑ Past ❑ Current

History of smoking: ❑ Current ❑ Past ❑ Non-Smoking

Access to guns? ❑ Yes ❑ No

Exposure to abuse/trauma: ❑ Yes ❑ No

Exposure to substance abuse: ❑ Yes ❑ No

Social History Over 16 Years

Living arrangements: ❑ Living Alone ❑ Living with others ❑ Living in a Facility ❑ Homeless

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Children: ❑ No children ❑ Children living at home ❑ Children living outside the home

Support System: ❑ Family Support ❑ Groups ❑ Church

Employment: ❑ Full-time ❑ Part-Time ❑ Unemployed ❑ Disabled ❑ Retired

Stressors: ❑ Transportation ❑ Family Medical ❑ Finances ❑ Work ❑ Recent Death ❑ Major Lifestyle changes

Legal history: ❑ No ❑ Past ❑ Current

History of abuse: ❑ Yes ❑ No

Domestic Violence History: ❑ Yes ❑ No

Access to guns: ❑ Yes ❑ No

Tobacco use: ❑ non-Smoking ❑ Daily smoker ❑ Occasional Smoker ❑ Former smoker

Alcohol use: ❑ Never Drinking ❑ Daily Drinking ❑ Occasionally Drinking ❑ Alcohol Abuse

Recreational drugs: ❑ Never a problem ❑ A current Problem ❑ A past problem

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INITIAL QUESTIONNAIRE

Over the last 2 weeks:	Not at all	Several days	More than ½ the days	Nearly every day	
Little interest in doing things	0	1	2	3	
Feeling down, depressed, or hopeless	0	1	2	3	
Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3	
Feeling tired/little energy	0	1	2	3	
Poor appetite or overeating	0	1	2	3	
Feeling bad about yourself	0	1	2	3	
Trouble concentrating	0	1	2	3	
Moving/speaking slowly or being fidgety/restless	0	1	2	3	
Death wishes, Suicidal thoughts, intentions or plans	0	1	2	3	
Thoughts of harming others	0	1	2	3	Total:
Column totals:					

How Difficult have these problems made it to work, take care of things at home or get along with others.	Not difficult	Somewhat Difficult	Very difficult	Extremely difficult	
Feeling nervous, anxious or on edge	0	1	2	3	
Not being able to stop or control worrying	0	1	2	3	
Trouble relaxing	0	1	2	3	
Being so restless it's hard to sit still	0	1	2	3	
Becoming Easily annoyed or irritable	0	1	2	3	
Feeling afraid as if something terrible might happen	0	1	2	3	Total:
Column totals:					

Please check which option best describes you:

How old were you when you first felt depressed? ❑ As long as I can remember ❑ Grade school ❑ Middle school ❑ High School ❑ 18-24 ❑ >24

How Many episodes of depression have you had? ❑ 1 ❑ 2-4 ❑ 5-6 ❑ >10

Have antidepressants ever caused? ❑ Excessive Energy ❑ Severe Insomnia ❑ Agitation/Irritability ❑ Racing Thoughts ❑ Talking A lot.

How many antidepressants have you tried (if any)? ❑ None ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ >5

Has an antidepressant you took before worked and then stopped? ❑ Yes ❑ No

Do your episodes Start gradually or suddenly? ❑ Gradually ❑ Can't Say ❑ Suddenly.

Did you have postpartum depression? ❑ N/A ❑ No ❑ Within 6 Months ❑ Within 2 Months ❑ Within 2 Weeks

Do you have major changes in mood at different times of the year? ❑ No Effect of time of year ❑ Yes, Seasonal Shifts

When you are feeling depressed do you sleep differently? ❑ No ❑ Sleep Less ❑ Sleep More

When you are feeling depressed do you eat differently? ❑ No ❑ Eat Less ❑ Eat More

When you are depressed what happens to your energy? ❑ Nothing ❑ It Varies a lot ❑ Very low ❑ Extremely low.

Please circle which option best describes you:

In episodes have you lost contact with reality such as Delusions, Voices or people thinking you were odd? ❑ Yes ❑ No ❑ Voices ❑ Visual

Have you ever had a feeling of paranoia as if someone is watching you or is after you? ❑ Yes ❑ No

Has anyone ever told you "You aren't doing well."? ❑ Yes ❑ No

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Mood Check Part A

Please place a check after the statements below that accurately describe you:	
I notice that my mood and/or energy levels shift drastically from time to time.	
At times, I am moody and/or my energy level is very low and at other times its very high.	
During my low phases I feel the need to stay in bed, get extra sleep and have little motivation to get things done.	
During this time, I tend to put on weight.	
During my low phases I sometimes feel blue, sad, or depressed.	
During my low phases I Sometimes I feel helpless/hopeless and sometimes even suicidal.	
My low phases typically last a few weeks and other times they last a few days.	
I have periods of feeling normal in between my highs and lows and my energy and ability to function is not disturbed.	
I then notice shifts in the way I feel.	
My energy increases to above what is normal and I often get many things done that I normally couldn't.	
Sometimes during these high periods, I feel hyper or like I have too much energy.	
I sometimes also feel irritable, edgy, or aggressive.	
During my high periods I sometimes take on too much.	
During my high periods I tend to spend too much money in ways that cause trouble.	
I am sometimes more talkative, outgoing, or sexual during this high period.	
At times my behavior during my high periods tends to seem strange or even annoy others.	
At times I can get into difficulty with coworkers or police during these periods.	
I tend to increase my alcohol or non-prescription drug use during the high periods.	
TOTAL:	

Part B: **The statements in Part A (not just those checked) Describe me:** (*Please Check one of the answers below)*

❑ Not at all ❑ A Little ❑ Fairly Well ❑ Very Well

Total between Part A & B_____

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Review of Systems Questionnaire

Constitutional Symptoms

- Fever ❍ No ❍ Yes
- Malaise ❍ No ❍ Yes
- Fatigue ❍ No ❍ Yes
- Headaches ❍ No ❍ Yes
- Recent weight changes ❍ No ❍ Yes
- Sleep disturbance ❍ No ❍ Yes
- Lightheaded/dizziness ❍ No ❍ Yes
- Appetite changes ❍ No ❍ Yes
- Sedation ❍ No ❍ Yes
- Pain ❍ No ❍ Yes

Allergies / Immunologic

- Difficulty breathing ❍ No ❍ Yes
- Unusual sneezing ❍ No ❍ Yes
- Runny nose ❍ No ❍ Yes
- Itchy/teary eyes ❍ No ❍ Yes
- Allergic response to materials/food/animals ❍ No ❍ Yes

Integumentary

- Rash or itching ❍ No ❍ Yes
- Change in skin color ❍ No ❍ Yes
- Change in hair or nails ❍ No ❍ Yes
- Varicose veins ❍ No ❍ Yes

Neurological

- Convulsions or seizures ❍ No ❍ Yes
- Numbness or tingling Sensations ❍ No ❍ Yes
- Local weakness ❍ No ❍ Yes
- Head injury ❍ No ❍ Yes
- Tremors ❍ No ❍ Yes

Eyes

- Blurred vision ❍ No ❍ Yes
- Double vision ❍ No ❍ Yes
- Loss of vision ❍ No ❍ Yes
- Glaucoma ❍ No ❍ Yes

Ear Nose Mouth and Throat

- Tinnitus ❍ No ❍ Yes
- Hearing Loss ❍ No ❍ Yes
- Chronic sinus problem or rhinitis. ❍ No ❍ Yes
- Sore throat or voice change ❍ No ❍ Yes
- Swollen glands (In neck) ❍ No ❍ Yes

Gastrointestinal

- Polyps ❍ No ❍ Yes
- Dysphagia ❍ No ❍ Yes
- Nausea ❍ No ❍ Yes
- Diarrhea ❍ No ❍ Yes
- Dyspepsia ❍ No ❍ Yes
- Constipation ❍ No ❍ Yes
- Abdominal pain ❍ No ❍ Yes
- Rectal bleeding or blood in stool ❍ No ❍ Yes
- Black tarry stools ❍ No ❍ Yes
- Stomach ulcers ❍ No ❍ Yes

Musculoskeletal

- Joint pain ❍ No ❍ Yes
- Muscle pain ❍ No ❍ Yes
- Back pain ❍ No ❍ Yes
- Difficulty in walking ❍ No ❍ Yes

Hematologic/Lymphatic

- Anemia ❍ No ❍ Yes
- Enlarged glands ❍ No ❍ Yes
- Bleeding or bruising tendency ❍ No ❍ Yes
- Slow healing after cuts ❍ No ❍ Yes
- Phlebitis ❍ No ❍ Yes

Respiratory

- Cough ❍ No ❍ Yes
- Difficulty breathing ❍ No ❍ Yes
- Wheezing ❍ No ❍ Yes

Cardiovascular

- Chest pain or pressure ❍ No ❍ Yes
- Heart murmur ❍ No ❍ Yes
- Swelling of legs or feet ❍ No ❍ Yes
- Arrhythmias ❍ No ❍ Yes
- Palpitations ❍ No ❍ Yes
- Shortness of breath ❍ No ❍ Yes
- High blood pressure ❍ No ❍ Yes

Female Only

Date of last menstrual period_____

- Currently pregnant ❍ No ❍ Yes

Genitourinary

- Frequent urination ❍ No ❍ Yes
- Burning or painful urination ❍ No ❍ Yes
- Incontinence ❍ No ❍ Yes
- Kidney stones ❍ No ❍ Yes

Endocrine

- Intolerance to heat or cold ❍ No ❍ Yes
- Excessive thirst or urination ❍ No ❍ Yes
- Dryness of skin ❍ No ❍ Yes
- Thyroid problem ❍ No ❍ Yes
- Glandular or hormone problem ❍ No ❍ Yes

Pain Scale

Pain on scale of 0 - 10 _____