the CENTER for STRESS MEDICINE

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
- Bioidentical Hormone Replacement Therapy
- Mental Health Physical
- Psychiatric Evaluation and Treatment
- Brain Imaging
- Genetic Testing
- Health and Wellness
- Skin Care/Health
- Mental Health
- Medication Insights
- Cancer Screening

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 you current spiritual practice:_____
Have you had any blood work drawn in the last year? YES NO
Please list ALL current medications: _____
_____
Please list ALL current over the counter medications or 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