Michelle K Jackson ND, PC.
365 NE Kearney Ave
Bend, OR 97701
Phone (541) 385-0775
Fax (541) 330-1466
www.drjacksonnd.com
office@drjacksonnd.com

Welcome

Dear Patient:

We would like to take this opportunity to thank you for choosing Dr. Michelle K. Jackson ND, for your health care needs. Please fill out this form as completely as possible and bring them with you to your appointment. If you have copies of any previous laboratory work through other doctors, please bring these also. Should you have any questions, please contact our office at (541) 385-0775. We will be happy to help you.

Your first appointment will take 60-90 minutes on average, which includes consultation time with the doctor and examination if needed and time allows. Any laboratory tests or pharmacy recommended are not included in your office call fee. Due to the extended time set aside especially for you, we must ask that, should you need to reschedule or cancel your appointment, that you contact the office 24 to 48 hours prior to your appointment (via voice mail is okay also). Unless notification is given, the first office call will be charged to your account. Please keep this in mind to avoid these charges.

Dr. Jackson is available by email or phone for questions. Simple questions may be handled by a brief exchange of messages, otherwise, it is better to schedule appointments. While we do not charge for very brief issues requiring five minutes or less of DrJackson's time, letter writing, form completion, records review, laboratory result review, medication prior authorizations, and other requests outside of scheduled appointments will incur a charge, demanding on the amount of time needed.

We are looking forward to seeing you on: ____

INFORMATION ABOUT THE DOCTOR

Dr. Michelle Jackson is a STATE LICENSED NATUROPATHIC PHYSICIAN. Dr Jackson's undergraduate education was completed at the University of Colorado at Boulder with a major in Kinesiology.

Dr. Jackson graduated from the National College of Naturopathic Medicine in Portland, Oregon. She received her Doctorate in Naturopathic Medicine in June of 2001. Dr. Jackson is a member of the American Association of Naturopathic Physicians and the Oregon Association of Naturopathic Physicians.

Dr Jackson conducts a family practice clinic, treating all ages and most diseases. She also performs complete physicals, pap smears, necessary cultures, blood and urine tests. Licensed medical laboratories are used for all laboratory tests (Central Oregon Regional Laboratories, American Medical Testing Labs, US Biotek, and Diagnos-Techs). If X-rays, CT scans, or MRI's are needed, they are ordered through local hospitals or radiology centers. Dr Jackson works with, and refers out to, other health care specialists whenever the need arises. Dr Jackson also offers gentle manipulation therapies using both the Bowen Technique and CranioSacral therapy which can be effective for adults and children.

Our clinic's neuropathic pharmacy is on the premises so that naturopathic medications can be conveniently picked up during your scheduled visit. Mailings are done routinely so that refills do not require a trip to the office.
Thank you! We look forward to serving your health care needs!

Michelle K Jackson ND, PC.
365 NE Kearney Ave
Bend, OR 97701
Phone (541) 385-0775
Fax (541) 330-1466
www.drjacksonnd.com
office@drjacksonnd.com

Type of Practice

Dr. Jackson conducts a Family Practice, treating all ages and most diseases. She performs complete physicals, pap smears, cultures, blood, serum, urine and stool tests.
The following is a brief list of services Dr. Jackson is qualified to render to her patients:

NATUROPATHIC CARE

- Allergies – both food and environmental
- Ear, nose, and throat infections, pediatric care
- Well child exams
- Nutritional Counseling
- Botanical medicine
- Hypertension
- Immune support therapy
- Candida infections
- Cardiovascular problems
- Chronic fatigue syndrome
- Diabetes
- Fibromyalgia
- PMS and women's health
- Natural hormones replacement therapies/Bioidentical Hormone Replacement
- Annual Exams
- Bowen Technique
- CranioSacral Therapy
- Acne, psoriasis, eczema, dermatitis
- Digestive problems, ulcers, irritable bowel
- Attention deficit disorders with hyperactivity
- Arthritis, rheumatoid and osteoarthritis
- Thyroid Imbalances
- Adrenal Imbalances
- Weight management

Michelle K Jackson ND, PC.
365 NE Kearney Ave
Bend, OR 97701
Phone (541) 385-0775
Fax (541) 330-1466
www.drjacksonnd.com
office@drjacksonnd.com

COMMITMENT TO CHANGE

Policies are necessary for any office to run effectively. However, it is important to keep in mind the goals of the office. We are here to help people change in positive ways. To be committed to positive changes means openness, collaboration, and personal responsibility. Ultimately, your health is your responsibility. Our job is to facilitate your progress to health.

SERVICES

A first office call generally runs 60 minutes. Return office calls are scheduled for approximately 30 minutes. It is important to be on time because appointments will not be extended beyond the scheduled time as a result of a late arrival. ***Because your initial appointment is held especially for you, we require a full business day's notice to cancel or reschedule your appointment.*** This office policy will be strictly enforced, so please give us 24 hours advance notice of your need to cancel/reschedule.

CHARGES AND PAYMENT

Charges are typically accumulated on the basis of length of visit. Physical therapy, laboratory testing, pharmacy items, house calls, consultations (phone included), letter writing and written summaries are examples of additional services rendered. ***Patients are advised that payment will be expected upon receipt of services or pharmacy. Payment may be made by check, cash, MasterCard or Visa.***

INSURANCE COVERAGE

We are an **Out-of-Network Provider** with all insurance companies. If you do have ***out-of-network Naturopathic benefits*** we will bill your insurance company for you. Please note that the full patient responsibility is due at the time of service. ***If insurance coverage for your visit is of the utmost importance, please check with your carrier prior to your scheduled appointment.***

EXAMPLES OF CURRENT FEES

First Office Call (approximately 60 minutes)……………….. Starting at $270.00
Return Office Call (approximately 30 to 45 minutes)……......$152.00 to $202.00
Letters …………………………………………………......Starting at $25.00

I have read and agree to abide by the above office policies:

____

Signed Date

Michelle K Jackson ND, PC.
365 NE Kearney Ave
Bend, OR 97701
Phone (541) 385-0775
Fax (541) 330-1466
www.drjacksonnd.com
office@drjacksonnd.com

OFFICE BILLING POLICY

TO ALL OF OUR INSURED PATIENTS: It is our policy to bill your primary insurance carrier as a courtesy to you if you have coverage for naturopathic services. However, your bill is always your responsibility because insurance is an agreement between you and your insurance carrier. **On your first visit we ask that you pay any un-met deductible amounts, co-insurance, and non-covered charges.** Upon adequate request time, our front office can help review your coverage and the estimated cost of your care prior to your visit. Please read and check the information below that applies to you.

_____ **PRIVATE INSURANCE:** Private insurance including managed care programs are accepted toward the payment of our fees if naturopathic services are covered under your policy. As stated above, we will bill your primary insurance company as long as deductibles, co-pays, and non-covered services are paid up front. We will give you a copy of the superbill so that you can bill your secondary insurance.

_____ **UNINSURED PATIENTS:** You are expected to pay for services as they are rendered. Payment may be made by cash, check, Visa or Mastercard. If you cannot make these arrangements, a payment plan may be set up for you by our front office assistant prior to treatment upon the doctor's approval.

_____ **HMO's in OREGON:** I understand that if I am seen without a referral I will be responsible for any charges incurred.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including attorney fees. I hereby authorize Dr. Michelle K. Jackson, ND, to release information necessary to secure the payment of benefits from my insurance company.

****I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION****

Patient's signature ____________________________________ Date ______________

Michelle K Jackson ND, PC.
365 NE Kearney Ave
Bend, OR 97701
Phone (541) 385-0775
Fax (541) 330-1466
www.drjacksonnd.com
office@drjacksonnd.com

Patient Information

Name ____ Soc. Sec. #: _______________________
Home Address ________________________________ City ______________ State ________ ZIP _______
E-mail Address ________________________________ Birthdate __________ Sex ______ Age ________
Home Phone ________________ Work Phone ________________ Cell Phone ________________
Live With: ___ Spouse ___ Parents ___ Relatives ___ Friend(s) ___ Alone ___ Other
Education: ___ Current Grade Level ___________________________________ School Attending
Religious Preference ____
Emergency Contact (Name, phone number, and relationship):____

INSURANCE

If you have no insurance, check here ☐
****Medicare DOES NOT PAY for the services of a Naturopathic Physician***

Insurance Co. _________________________________Subscriber's Name ____________________________
Subscriber's Birthdate _____________________ Policy Number ______________ Group Number __________

FINANCIAL AGREEMENT

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

____
Signature Date

AUTOMATIC RELEASE CONTRACT

I hereby authorize the release of any information necessary to provide appropriate medical care sent to Michelle K. Jackson ND. I further authorize the release of medical information to other health care providers for referral purposes only.

____
Signature Date

Michelle K Jackson ND, PC.
365 NE Kearney Ave
Bend, OR 97701
Phone (541) 385-0775
Fax (541) 330-1466
www.drjacksonnd.com
office@drjacksonnd.com

Patient Consultation Questionnaire

Dictated report and/or chart notes to follow

Patient Name: ______________________ Today's Examination Date: ______________

1. Primary Care or Referring Physician (Name, degree, address, ZIP, phone/fax) ______________________
____
2. Please additionally list the name of whoever else may have referred you for our services ______________
____

A NOTE TO OUR PATIENTS: Naturopathic and preventative health care are only possible when the physician has a complete picture of the patient physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire. This will make our consultation time much more efficient and is essential for your dictated report. Consider copying this for your own future records. Our initial examination involves an extensive review of this form with a dictated physician report including a physical examination when appropriate and treatment plan. **This form is for internal use and will not be released to any agency without your written authorization.**

I. MEDICAL PROBLEM LIST

A. In your opinion, what are your most important health concerns?

1. ______________ 6. ______________
2. ______________ 7. ______________
3. ______________ 8. ______________
4. ______________ 9. ______________
5. ______________ 10. ______________

Others: ____

B. Which of the above concerns are of most immediate concern to you? #?_______________

II. HISTORY OF THE PRESENT ILLNESS

A. Describe further your health concerns (problem list). What makes them better or worse?

Problem #1: ____

Problem #2: ____

Problem #3: ____

Problem #4: ____

Feel free to describe beyond your first four problems on the reverse side.

B. ETIOLOGY

How did these conditions develop? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify as having caused or clearly aggravated your health problems?

____
____
____
____

C. PRIOR TREATMENTS AND RESPONSE

Please list all of the former treatments you have used, both conventional and alternative, and the degree of effectiveness of each treatment. Please be specific about the benefits you received (if any) from each treatment. This greatly aids us in developing an optimal treatment plan for you.

____
____
____
____
____
____
____

III. PAST MEDICAL HISTORY

A. YOUR HEALTH HISTORY: Please check those conditions that apply to you.

Now	Past	Never	Condition
☐	☐	☐	**Anemia**
☐	☐	☐	**Arthritis**
☐	☐	☐	**Asthma**
☐	☐	☐	**Alcoholism**
☐	☐	☐	**Bleeding**
☐	☐	☐	**Cancer**
☐	☐	☐	**Colitis**
☐	☐	☐	**Heart Murmur**
☐	☐	☐	**High Blood Pressure**
☐	☐	☐	**Injury (serious)**
☐	☐	☐	**Kidney Disease**
☐	☐	☐	**Liver Disease/Jaundice**
☐	☐	☐	**Overweight**
☐	☐	☐	**Ulcers**
☐	☐	☐	**Other (Specify)** ____________________

Now	Past	Never	Condition
☐	☐	☐	**Diabetes**
☐	☐	☐	**Hypoglycemia**
☐	☐	☐	**Allergies**
☐	☐	☐	**Candida (yeast) Infections**
☐	☐	☐	**Emphysema**
☐	☐	☐	**Eczema**
☐	☐	☐	**Drug/alcohol use (Specify)**________________
☐	☐	☐	**Heachache**
☐	☐	☐	**Pneumonia**
☐	☐	☐	**Rheumatism**
☐	☐	☐	**Thyroid** ____Hyper ____ Hypo
☐	☐	☐	**Tuberculosis**
☐	☐	☐	**Venereal Disease**

CHILDHOOD ILLNESSES

Have you performed the “normal” immunizations schedule? ___________

☐ **Rubella (German 3-day measles)** ☐ **Measles (2 weeks)** ☐ **Mumps** ☐ **Chicken Pox**
☐ **Whooping Cough** ☐ **Polio** ☐ **Rheumatic Fever** ☐ **Scarlet Fever**
☐ **Roseola** ☐ **Asthma** ☐ **Others** ________________

☐ **Adverse reactions to childhood vaccinations?** ____

C. HOSPITALIZATIONS (List as best you can):

Type of illness or operation/procedure	Date	Summary of findings (if known)

D. IMAGING (Chest-Spinal x-rays, CT scans, Mammogram, Ultrasounds, MRI, Angiogram, Arterial-venous studies, etc):

	Date	Summary of findings (if known)

E. PROCEDURES (PAP, EKG, Stress test, holter monitor, spirometry, sigmoid/colonoscopy, TB test, IVP, cystoscopy, bronchoscopy). If older than 50, list date of last glaucoma check, etc.

	Date	Summary of findings (if known)

F. LAB (Blood, urine analysis, PSA, thyroid, etc.):	**Date**	**Summary of findings (if known)**

IV. <u>FAMILY HISTORY</u> Please list ages and if deceased, what they died from and at what age.
Please list any chronic health problems of your living parents or siblings.

A. ANCESTRAL MEDICAL HISTORY

<u>Mother's Side</u>

Grandfather ______________________

Grandmother ______________________

Mother ______________________

<u>Father's Side</u>

Grandfather ______________________

Grandmother ______________________

Father ______________________

Sisters ______________________

Brothers ______________________

B. Has any BLOOD RELATIVE had any of the following:

Yes	No	Don't Know	
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Bleeding (easily)
☐	☐	☐	Cancer (type __________)
☐	☐	☐	Diabetes
☐	☐	☐	Eczema
☐	☐	☐	Glaucoma
☐	☐	☐	Gout
☐	☐	☐	Other (Specify) __________________

Yes	No	Don't Know	
☐	☐	☐	Hay Fever
☐	☐	☐	Heart attack
☐	☐	☐	High blood pressure
☐	☐	☐	Seizure/Epilepsy
☐	☐	☐	Sickle Cell Anemia
☐	☐	☐	Stroke
☐	☐	☐	Thyroid (hyper/hypo)
☐	☐	☐	Tuberculosis (TB)
☐	☐	☐	Venereal Disease (Specify type) ________________

V. ALLERGIC HISTORY

A. Please list any drugs, foods, airborne or other substances that you are allergic to:

____

____

B. What happens when you have an "allergy attack"?

____

C. List any chronic problems you have that may have resulted from a prior medication? What was the medicine and what problems did you develop?

____

____

D. Please bring all prescriptions, over the counter drugs and supplements with you to your 1st visit

E. Please list all prescription and over the counter medications that you take, dose per pill, number of pills taken and the time of day(e.g. lanolin 0.25mg 2 pills 9am and 9pm).

____

____

F. Please list any natural medications that you currently take (Vitamins, minerals, herbs, homeopathic). Number of pills and time of day taken.

____

____

G. Please list any prescriptions, over the counter or natural medications that you recently stopped taking.

____

____

VI. HEALTH HABITS

A. ALCOHOL

How often do you drink: wine ______________ beer ______________ other alcohol _______________
(daily, weekly, monthly)

B. TOBACCO

Do you use tobacco or have you in the past? __ Yes __ No. Total years stopped smoking: ___ Total packs/years smoked:___

C. OTHER DRUGS

Do you now or have you in the past used marijuana or other drugs? ___ Yes ___ No. Please list _______________________

D. CHEMICAL EXPOSURES

Have you ever been exposed to toxic chemicals, solvents, or other possible toxins? ___Yes ___No

If yes, please explain: ____

____

E. EXERCISE

Do you exercise? ____Yes ____No. Which of the following do you do on a regular basis? ____Jog _____Swim _____ Walk

____ Bicycle ____Gardening ____Breathing Exercises ____Weightlifting ____Other ______________________________

How often do you exercise? _______________________________________

F. RELAXATION

Do you make time for rest, relaxation, or prayer during the day and/or before bed? ___Yes ___No

How often? ______________________________ How do you relax? ____

G. HOBBIES

What are your interests or hobbies? ____

H. DIET

How many meals do you generally eat each day? ___One ___Two ___Three ___More than three

Where do you usually buy your food? ____

Who cooks the food you eat? ____

List the primary foods included in your diet.

____

____

____

List the foods you exclude from your diet.

____

____

List any of the following (and relative amounts) eaten regularly by you. Coffee, caffeinated teas, highly seasoned foods, processed foods, preservatives, refined foods, and other foods you suspected may be harmful to your health.

____

____

List any foods you crave, regardless of their nutritional value (include sweets, chocolate, salty, sour, bread, rich/fatty foods, etc): ____

____

____

List any foods to which you have a bad reaction:

____

____

____

Are you satisfied with your diet as it is now? _____ Yes _____ No If no, why not? ________________________________

____

I. WATER CONSUMPTION

Are you thirsty? _____Yes _____No. Amount of liquid you drink each day: ______________________________

What temperature do you prefer to drink? _____ Hot _____ Cold _____Room temperature

J. SLEEP

Do you have trouble falling asleep? ___Yes ___ No. If yes, what keeps you up?

____

Do you sleep straight through the night? ___Yes ___No. Do you wake feeling refreshed? ___Yes ___ No

VII. REVIEW OF SYMPTOMS

NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER
(1) = MILD (2) = MODERATE (3) = SEVERE
next to the symptoms that apply to you NOW or in the PAST.

Integumentary (Skin)

Now	Past	
		Skin rough, dry, scaly, bumpy, itchy (please circle if appropriate)
		Rashes, warts, moles, cysts (circle those appropriate) Have any of these changed in size or color recently? ______________________
		Pimples. List location(s)______________________
		Loss of hair. List location(s) ______________________
		Hives. List what causes them ______________________

Hematopoietic, Lymph, Immune

Now	Past		Now	Past	
		Painful lymph nodes			Wounds heal slowly
		Difficulty stopping bleeding			Anemia
		Bruising easily			Fluid retention

X. **REVIEW OF SYMPTOMS - Continued**

NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER
(1) = MILD (2) = MODERATE (3) = SEVERE
next to the symptoms that apply to you NOW or in the PAST.

Head

Now	Past		Now	Past	
		Dizziness (Vertigo)			Double vision
		Severe headaches			Fainting spells
		Seizures, convulsions			

Eyes

Now	Past		Now	Past	
		Itching			Puffy lids
		Blurring of vision			Allergic shiners
		Tearing			Pain from Bright Light

Ears

Now	Past		Now	Past	
		Fluid in ears			Excessive ear wax
		Ringing in ears			Hearing loss

Nose

Now	Past		Now	Past	
		Nose bleeds			Loss of smell
		Sinus congestion			Sinus infections
		Postnasal discharge			

Mouth

Now	Past		Now	Past	
		Sore mouth or tongue			Bleeding Gums
		Speech difficulties			Cold sores, blisters

Throat

Now	Past		Now	Past	
		Persistent hoarseness			Loss of voice
		Difficulty swallowing			Pain
		Recurrent strep throat			Chronic sore throat

Neck

Now	Past		Now	Past	
		Stiffness			Injuries
		Swelling			Pain (describe area) ________________

X. REVIEW OF SYMPTOMS - Continued

NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER
(1) = MILD (2) = MODERATE (3) = SEVERE
next to the symptoms that apply to you NOW or in the PAST.

Pulmonary

Now	Past		Now	Past	
		Chest pain when breathing			Night sweats
		Wheezing			Shortness of breath
		Difficulty breathing at night			Daily cough

Have you ever been exposed to TB (tuberculosis)? _____Yes ____No

Cardiovascular

Now	Past		Now	Past	
		Chest pain when walking			Leg vein problems
		Chest pain when sit/lying			Leg pain when walking
		Ankle or abdominal swelling			Numbness/tingling in extremities
		Hear palpitations – fibrillation, flutter, skipping beat, beating fast, beating slow (circle if yes)			Heart murmur (list type) _______________

Have you had rheumatic fever? _____Yes _____No If yes, when? ____

Gastrointestinal

Now	Past		Now	Past	
		Constipation			Stomach pain 5 to 6 hours after eating, usually at night, relieved by eating or drinking
		Indigestion 2 to 3 hours after a meal with fullness, bloating, or pain			Alternating constipation and diarrhea
		Diarrhea			Above symptoms worse w/worry, stress, tension
		Change in bowel movements			Bad breath
		Strain at stooling			Sudden strong cravings for sweets or alcohol
		Heavy, full after eating			Intestinal parasites suspected
		Hemorrhoids			Loss of appetite
		Black stools			Insatiable appetite
		Blood in stools			Over weight
		Heartburn			Under weight
		Excessive belching			Compulsive eating/Addictive eating
		Excessive lower bowel gas			Distress from fat or greasy foods
		Stomach cramps, colic			Anorexia/Bulimia
		Bad taste in mouth			Stomach/abdominal pain

X. REVIEW OF SYMPTOMS - Continued

NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER
(1) = MILD (2) = MODERATE (3) = SEVERE
next to the symptoms that apply to you NOW or in the PAST.

Urinary

Now	Past		Now	Past	
____	____	Frequent urination	____	____	Painful urination
____	____	Night urination	____	____	Difficulty starting urine
____	____	Difficulty holding urine	____	____	Blood in urine

Male Reproductive

Now	Past		Now	Past	
____	____	Prostate problems	____	____	Painful erection
____	____	Swelling, lumps in testicles	____	____	Difficulty achieving/maintaining erection
____	____	Pain in testicles	________		Date of last prostate examination

Female Reproductive

Now	Past		Now	Past	
____	____	Lumps in breast(s)	____	____	Painful Intercourse
____	____	Breast Pain	____	____	Lack of sexual desire
____	____	Pelvic Pain	____	____	Never/seldom have orgasms
____	____	Vagina Discharge	____	____	Menstruation excessive
____	____	Vaginal itching/burning	____	____	Menstruation absent
____	____	Genital eruptions	____	____	Bleed between periods
____	____	Genital eruptions	____	____	Spot between periods
________		Type?			

Are you currently sexually active? _____Yes _____No. Current form of contraception? ____________________________

Age of first menstruation? _______________+

Periods occur every _____ days. Regular? ____Yes _____ No. Periods usually last_____ Days (average)

Date of last period? ____

Do you experience Premenstrual Tension symptoms such as nervous tension, mood changes, depression, breast tenderness, weight gain before, during, or after menstruation? Please explain symptoms and timing of symptoms.____

____

____

Have you in the past, or do you currently have problems with infertility? ______________________________

______ **# of pregnancies** ______ **# of births** _____ **# of miscarriages** _____ **# of abortions**

Any complications with pregnancy? _____ **Yes** _____ **No. If yes, please explain.** __________________________

____

VII. REVIEW OF SYMPTOMS - Continued

NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER
(1) = MILD (2) = MODERATE (3) = SEVERE
next to the symptoms that apply to you NOW or in the PAST.

Thyroid

Now	Past	
		Overweight
		Difficulty losing weight
		Constipation
		Tired upon arising/Easily fatigued
		Low sex drive
		Dry or scaly skin
		Chilly/sensitive to cold

Now	Past	
		Decreased appetite
		Low body temperature
		Heart palpitations
		Irritable/restless
		Increased appetite
		Underweight
		Flush/get hot easily

Adrenals

Now	Past	
		Easily stressed
		Easily/chronically fatigued
		Dizziness
		Headaches
		Crave salt

Now	Past	
		Nails weak, ridged
		Facial hair (women)
		Rheumatism/arthritis
		Poor circulation
		Increased blood pressure

Central and Peripheral Nervous System

Now	Past	
		Dizziness regularly
		Convulsions (seizures)
		Tremor (shaking, trembling)
		Blurred/double vision

Now	Past	
		Numbness or tingling (circle one)
		Temporary loss of sensation
		Lack of strength
		Where? ____________________________
		Continual headaches

Mental Status

Now	Past	
		Anxiety/Restlessness
		Lack of self-confidence
		Excessive worry
		Depression/Despair/Discontent
		Suicidal thoughts
		Suicidal attempts
		Loneliness/feel alone
		Mood swings
		Confident, secure

Now	Past	
		Memory difficulty, forgetting
		Mental confusion
		Decreased concentration, comprehension
		Shy, timid
		Critical of self
		Critical of others
		Sensitive to noise
		Fears- (Please specify)____________________________________
		____________________________________

VII. REVIEW OF SYMPTOMS - Continued

NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER
(1) = MILD (2) = MODERATE (3) = SEVERE
next to the symptoms that apply to you NOW or in the PAST.

Spine and Extremities

Now	Past	
		Joint swelling
		Backaches
		Burning on soles of feet or palms of hands

Now	Past	
		Coughing, at stools
		Sneezing /straining stools
		Rheumatism/arthritis

Please mark your problem and painful areas as exactly as possible with an "X" on the diagram below.