Patient Name: _____ **Date:** _____

Current Medication/Supplement List

Prescriptions	**Supplements**

List any changes you have made to your medications/supplements below.

_____

_____

Symptom List

Check any symptoms you are currently experiencing:

Joint Pain A.M. Stiffness Cramps	Weakness Headache Aches Light Sensitivity Slow Mental Process	Appetite Changes/Swings Difficulty Regulating Body Temp Increased Urinary Frequency
Fatigue	Difficulty Concentrating	Static Shocks Vertigo
Unusual Skin Sensitivity Tingling	Shortness of Breath Sinus Congestion	Memory Impairment Decreased Word Finding
Cough Excessive Thirst Confusion	Abdominal Pain Diarrhea Numbness	Tearing of Eyes Disorientation Metallic Taste
Red Eyes Blurred Vision	Night Sweats Mood Swings	Ice-Pick Pain

Dizziness/Fainting	Fever/Chills	Nausea/Vomiting	Constipation
Heartburn	Gas/Bloating	Weight Changes	Tremor
Anxiety	Depression	Insomnia	Difficulty Swallowing
Heart Palpitations	Dental Problems	Ear/Throat Pain	Urinary Discomfort

List priorities for your appointment today, including any additional/new symptoms, questions, or concerns (lab review, medication refill, new tests, etc):

_____

_____

_____

_____

_____

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*****PLEASE FILL OUT ON THE DAY OF YOUR APPOINTMENT*****