Follow Up Visit:
647 Camino De Los Mares #226
San Clemente, CA 92673
Ph: 949 4899898 Fax: 949 4892569

Send a copy to:_____
_____
_____

PLEASE FILL IN THIS PAGE. THE OTHER SIDE IS FOR THE CLINICIAN
Patients Name: _____ Date: ____/____/_____
Have you moved? Y__ No__ New address=_____
Have you changed your phone number? Y__N__ If so new number___-_____-_____
What is your e mail address?_____@_____?

1. Please fill out this side prior to your visit. Write down any concerns, side effects or other issues of concern

_____
_____

2. Fill in all the medications you are currently taking from our office or other offices and list any herbs or supplements or over the counter pills you are taking.

Medications and supplements you are taking:

MEDICATION NAME	SIZE OF PILL? The number of mg's	HOW MUCH TAKEN? 1 or 2 etc	WHAT TIME IS IT TAKEN?

A. CURRENT SYMPTOMS (Check all that apply **1 = Mild, 2 =Moderate, 3 = Severe**

___ Poor Sleep
___ Poor Appetite
___ Increased appetite
___ Weakness
___ Decreased sex drive
___ Hyperventilation
___ Palpitations
___ Depression
___ Nausea
___ Headaches
___ Crying easily
___ Indecisiveness
___ Work problems
___ Irritability
___ Personality changes
___ Constipation
___ Diarrhea
___ Weight loss
___ Tiring easily
___ Abdominal discomfort
___ Feeling hopeless
___ Lack of interest
___ Anxiety
___ Feelings of guilt
___ Family problems
___ Poor attention span
___ Ringing in ears
___ Other: _____
___ Physical complaints
___ Feelings of inferiority
___ Hearing voices
___ Seeing things
___ Paranoia
___ Anger
___ Fearfulness
___ Phobias
___ Low self esteem
___ Socially withdrawn
___ Dry mouth
___ Nightmares
___ Dizziness
___ Other: _____
___ Racing heart
___ Suicidal feelings
___ Blurred vision
___ Shaky inside
___ Avoid people
___ Can't have fun
___ Short temper
___ Worrying a lot
___ Inability to relax
___ Menstrual change
___ Numbness
___ Sexual problems
___ Shaky hands
___ Other: _____

B. (Check all problem arears that apply) **1=Mild, 2=Moderate, 3=Severe, 0=No problem**

____Hyperactivity
____Impulse control
____Follows directions
____Truancy
____Attention Span
____Concentration
____Finishes tasks
____Defiant
____Distractibility
____Frustration tolerance
____Anger/aggressiveness
____Running away
____Emotional meltdown
____Cooperativeness
____School performance
____Other

Follow-Up Med Visit Part Two…With or Without Counseling

Patient Name:_____Diagnosis_____

Blood Pressure: _____ Weight: _____ Pulse: _____ Height: _____ List as Appropriate

Note progress of case, complications, change in condition, instructions to patient:

1. Reason for Session: Follow Up Visit _____ Other _____ Current Situation _____

2. Current Stresses: a. Home: _____ b. Work: _____c. School: _____d. Social interaction_____

3. High Risk Factors Present: Yes ____ No ____ Suicidal no intent: ___ Suicidal with intent: ___ Plan: _____
Prior Attempt _____ If yes, please explain: _____

4. Interventions used: Counseling _____ Education: _____ Change Meds_____Diagnostic tests: _____
Assist with problem solving: _____Reflective listening and communication skills: _____

Other: _____

5. Change in Treatment Plan or goals when appropriate: What are the goals of treatment:
_____

6. If medical management is provided: discuss any clinical or medical disorder that may be influencing or affecting the patient's psychiatric status_____

7. **Is the patient: Better_____Same_____Regressed_____Explain,If appropriate:_____**
_____

8. Overall Assessment and recommendations
A. _____

B. _____

C. _____

9. Instructions to the Patient
A._____

B. _____

C._____

10. Note patient's response to the treatment plan including compliance, side effects, symptom reductions, medication adjustments, augmentations and/or other changes to the plan. Comment on the appropriate issues:
Have you talked about and gotten informed consent re: off label use of meds: Yes ___ No___ Which ones:
_____
_____
_____
_____
Signature of Clinician: M.D., P.A., R.N.P.: _____ Counter signature: _____ Date: ____/___/____

Date of next appointment: _____/_____/_____