In order to confirm your scheduled teletherapy appointment, you must complete this form and email the completed form to jtarnow@tarnowcenter.com one week to 48 hours prior to your scheduled appointment or **your appointment will be canceled/rescheduled**.

- **You must call our office at the time of your scheduled appointment**

If you are not able to comply with the steps above, please call our office and reschedule your appointment for an in-person visit. We will make a reminder call two days prior to your appointment.

Name: _____ Appointment Date: _____

Email: _____ Phone: _____

Date of Birth: _____ Your Name if parent or guardian: _____

**** PLEASE PROVIDE 2 BLOOD PRESSURE/PULSE IF HIGHER THAN USUAL***

Blood Pressure: _____ Pulse: _____ Ht. _____ Wt. _____

Date/Time Taken: _____

Blood Pressure: _____ Pulse: _____ Date/Time Taken: _____

Please List any Allergies: _____ ☐ None

## All Current Medications (please list prescription, herbal remedies, and over the counter medications):

| | | |
|---|---|---|
| Medication: _____ | Dose in mg: _____ | How Often: _____ |
| Medication: _____ | Dose in mg: _____ | How Often: _____ |
| Medication: _____ | Dose in mg: _____ | How Often: _____ |
| Medication: _____ | Dose in mg: _____ | How Often: _____ |
| Medication: _____ | Dose in mg: _____ | How Often: _____ |
| Medication: _____ | Dose in mg: _____ | How Often: _____ |
| Other: _____ | Dose in mg: _____ | How Often: _____ |
| | | |

| |
|---|
| Other: _____ Dose in mg: _____ How Often: _____ |
| Other: _____ Dose in mg: _____ How Often: _____ |
| Reaction to Medications: ☐ Yes ☐ No If Yes, explain: _____ _____ |

## Current Pharmacy: Name: _____ Phone: _____ Location: _____

## Significant Changes:

Rate changes in symptoms overall since last appointment (Current severity rating):

☐ More Severe ☐ Much Worse ☐ No Change ☐ Less Severe ☐ Much Improved ☐ Resolved/Absent

## Please choose an item for each symptom listed below. If the item does not apply choose no change)

| Mood/Behavior | Physical |
|---|---|
| Anxiety ☐ Increased ☐ Decreased ☐ No Change | Weight ☐ Increased ☐ Decreased ☐ No Change |
| Anger ☐ Increased ☐ Decreased ☐ No Change | Appetite ☐ Increased ☐ Decreased ☐ No Change |
| Depression ☐ Increased ☐ Decreased ☐ No Change | Headaches ☐ Increased ☐ Decreased ☐ No Change |
| Hyperactivity ☐ Increased ☐ Decreased ☐ No Change | Injury to Self ☐ Increased ☐ Decreased ☐ None |
| Impulsivity ☐ Increased ☐ Decreased ☐ No Change | Other _____ ☐ Increased ☐ Decreased ☐ No Change |

## Productivity

### Concentration
☐ Increased ☐ Decreased ☐ No Change

### Attention
☐ Increased ☐ Decreased ☐ No Change

### Memory
☐ Increased ☐ Decreased ☐ No Change

### Activity
☐ Increased ☐ Decreased ☐ No Change

### Social Life
☐ Increased ☐ Decreased ☐ No Change

## Sleep

### Sleep Quality
☐ Normal/Refreshing ☐ Restless ☐ Delayed Onset
☐ Nightmares ☐ Oversleeps

### Sleep Alone
☐ Yes ☐ No -Please explain sleeping issues:

_____

_____

_____

_____

### Current Mood Rating (1-10)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

## Current Medical Problems since last visit:

Heart Problems:
☐ Yes ☐ No -If yes, explain: _____
_____

Stomach Problems:
☐ Yes ☐ No -If yes, explain: _____
_____

Bowel Problems:
☐ Yes ☐ No -If yes, explain: _____
_____

Neurological Problems:
☐ Yes ☐ No -If yes, explain: _____
_____

(Current Medical Problems Since Last Visit Continued…)
Respiratory Problems:

☐ Yes ☐ No -If yes, explain: _____

_____

## Substances Used:

☐ None

☐ Tobacco
Type and Amount Used:_____

☐ Caffeine
Type and Amount Used: _____

☐ Alcohol
Type and Amount Used: _____

☐ Street Drugs
Type and Amount Used: _____

Are you currently working with a therapist? ☐ Yes ☐ No If yes, who: _____

Contact (Email/Phone) Information: _____

Any Other Concerns or New Developments since your last visit?:

_____

_____

_____

_____

_____

_____

_____