Tarnow Center Follow-Up Questionnaire

Patient Name: _____ Today's Date: _____

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

Please List any Allergies: _____

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

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

Sleep

Concentration ☐ Increased ☐ Decreased ☐ No Change	Sleep Quality ☐ Normal/Refreshing ☐ Restless ☐ Delayed Onset ☐ Nightmares ☐ Oversleeps
Attention ☐ Increased ☐ Decreased ☐ No Change	Sleep Alone ☐ Yes ☐ No -Please explain sleeping issues: _____ _____ _____ _____
Memory ☐ Increased ☐ Decreased ☐ No Change	
Activity ☐ Increased ☐ Decreased ☐ No Change	
Social Life ☐ Increased ☐ Decreased ☐ No Change	

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: _____

_____

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? ☐ Ye ☐ No If yes, who: _____

Contact (Email/Phone) Information: _____

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

_____

_____

_____

_____

_____

_____

_____

_____