

Patient Registration

(Please Print Clearly)

Today's Date ____/____/____

Patient's Full Name _____ Date of Birth ____/____/____

Marital Status: S M D W Gender: M F NB Pronouns: _____

Address _____ City _____ State _____ Zip _____

Phone #s: Home () _____ Work () _____ Cell () _____

Please circle which number is best to call home/work/cell May a private voice message be left for you? YES/ NO

Guardian for child _____ Relationship _____ Phone _____

Address (if different) _____

Patient's Employer _____ E-mail: _____

(Note that email generally and use of employer's email is not private.)

Address _____ City _____ State _____ Zip _____

Preferred method of contact: (circle one) phone call email USPS mail

Spouse's/Partner's Name _____

Spouse's/Partner's Employer _____ Daytime # () _____

Emergency Contact _____ Phone # () _____

(Other than Spouse/Partner)

Is there anyone you with whom you want us to share your medical information?

Name & relationship

Name & relationship

Is there anyone with whom you do not want us to share your medical information ?

(The Doctor is not required to honor your request if it is not in your medical best interests. Please discuss this with the doctor.)

Financial Information

Financially Responsible Person _____ Relationship _____

Address (if different) _____ City _____ State _____ Zip _____

Are you covered under Medicare? Y or N Medicare # _____

Primary Health Insurance Company:

Secondary Health Insurance Company:

Identification #

Identification #

Group #

Group #

Subscriber

Subscriber

Subscriber's Date of Birth ____/____/____

Subscriber's Date of Birth ____/____/____

Effective Date

Effective Date

Primary Care provider and phone number _____

Referred by: _____

Please continue onto next page and sign.

Scoville Osteopathic Healthcare, P.C.

10325 Lloyd Road / Potomac, MD 20854 / 301-304-3330 / scovilleosteopathichealth.com

Patient Registration (continued)

FINANCIAL POLICY: I certify that the information I have reported is correct. I acknowledge that it is the policy of this office to collect full payment at the time of each visit. I understand that I am financially responsible for services provided. This office does not participate with health insurance, including Medicare or Medicaid, or provide workers compensation or disability reports. In addition, I agree that in the event I do not pay for services provided, I will pay for the cost of collection, and/or court costs and reasonable attorney fees should this be required. I understand that in the absence of a payment plan, outstanding balances may accrue 1.5% interest per month after 30 days.

CONFIDENTIALITY: As your physician, it is necessary to communicate in writing, by phone, fax or electronic communication to your primary care physician, or other health care providers, health insurance companies, Medicare/Medicaid or health claims clearinghouses. Communication between your doctors is in your best interest as it helps coordinate your medical care. Furthermore, health insurance companies may require certain information about you be sent to them and you have agreed to release this information as a participating member. The practice will make its best efforts to protect your privacy. This includes nondisclosure of your personal health information for marketing and fundraising purposes.

I understand and agree that my personal health information may be transmitted by computer to laboratories and or consulting health care practitioners to facilitate my medical care. I acknowledge that I have had an opportunity to read the office’s Notice of Privacy Practices and Health Care Disclosure Information that contains a description of the uses and disclosures of my personal health information. I understand that this information may be updated and I will be able to see the new information. The policy of this office is to strive to be in compliance with federal and state medical practice guidelines. A copy of this form can be considered as valid as the original.

CONSENT TO TREATMENT: We understand that you have come here to seek specialized treatment and we will endeavor to assist you in a speedy recovery, but of course we cannot guarantee any specific result.

I have read and understand the above office policies and consent to treatment by Dr. Scoville and her staff.

X Signature of Patient _____ Date _____
or Authorized Guardian if under 18 years old

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Scoville Osteopathic Healthcare, P.C.’s Notice of Privacy Practices.

Patient Name (Print): _____

X Patient Signature : _____ Date: _____

If signed by personal representative, please describe relationship to patient and authority to act on patients’ behalf:

FOR OFFICE USE ONLY

If acknowledgment not obtained, document reason: [] Emergency situation [] Patient refused to sign

Staff Initials: _____ Date: _____ [] Other: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy

Scoville Osteopathic Healthcare, P.C. is committed to protecting the privacy of health information. We are required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of Privacy Practices (Notice) of our legal duties and privacy practices regarding your PHI, and follow the terms of the Notice currently in effect.

This Notice tells you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information.

The privacy practices described in this Notice will be followed by all members of the workforce at Scoville Osteopathic Healthcare, P.C., including health care professionals, employees, trainees, students, and volunteers. Additionally, third parties (“business associates”) that provide services on our behalf will be required to comply with all applicable provisions.

How We May Use and Disclose Health Information About You

The following sections describe different ways we may use and disclose your health information. We abide by all applicable laws related to the protection of this information. Not every use or disclosure is listed. All of the ways we are permitted to use and disclose health information, however, will fall within one of the following categories:

Treatment.

We may use and disclose your health information to provide, coordinate, or manage your healthcare and related services. This includes consultation with other healthcare providers regarding your treatment and referral to another provider. For example, your primary care physician may share your health information with a specialist to coordinate your care.

Payment.

We may use and disclose your health information to obtain payment for services we provide. This includes billing activities, claims management, and collection activities. For example, we may send claims to your health insurance company containing certain health information to obtain payment for services we provided.

Healthcare Operations.

We may use and disclose your health information for our healthcare operations, which include internal administration and planning and various activities that improve the quality and cost-effectiveness of care. For example, we may use health information to evaluate the performance of our staff, assess the quality of care, or conduct training programs.

Other Uses and Disclosures We May Make Without Your Authorization:

As Required by Law. We may disclose health information when required by federal, state, or local law.

- **Law Enforcement.** We may disclose health information to law enforcement officials for law enforcement purposes as permitted by law.
- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose health information to coroners, medical examiners, and funeral directors to carry out their duties.
- **Organ and Tissue Donation.** We may disclose health information to organizations involved in the procurement, banking, or transplantation of organs, eyes, or tissue.
- **Research.** We may use or disclose health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your information.
- **To Avert a Serious Threat to Health or Safety.** We may use or disclose health information when necessary to prevent a serious threat to the health or safety of you, another person, or the public.
- **Specialized Government Functions.** We may disclose health information for military, national security, protective services, or correctional institution purposes as authorized by law.
- **Workers’ Compensation.** We may disclose health information as authorized by workers’ compensation laws. Unless you say no, to anyone involved in your care or payment for your care, such as a friend, family member, or any individual you identify.

Scoville Osteopathic Healthcare, P.C.

10325 Lloyd Road / Potomac, MD 20854 / 301-304-3330 / scovilleosteopathichealth.com

Substance Abuse Treatment.

We are required to protect the privacy and security of your substance use disorder patient records in accordance with 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2, the Confidentiality of Substance Use Disorder Patient Records (“Part 2”), in addition to HIPAA and applicable state law. In a civil, criminal, administrative, or legislative proceeding against an individual, we will not use or share information about your SUD treatment records unless a court order requires us to do so (after notice and an opportunity to be heard is provided to you, as provided in 42 CFR part 2) or you give us your written permission. You may report suspected violations to the U.S. Attorney for the judicial district in which the violation occurs. Contact information for the U.S. Attorney office where we operate is below:

U.S. Attorney for the District of Maryland

Main office: 36 S. Charles Street 4th Fl., Baltimore, MD 21201; Phone: (410) 209-4800

Southern Division: 6406 Ivy Lane Suite 800, Greenbelt, MD 20770; Phone: (301) 344-4433

Suspected violations by an opioid treatment program may be reported to the Substance Use and Mental Health Services Administration (SAMHSA), Opioid Treatment Program Compliance Office by phone at 204-276-2700 or online at OTPEXTRANET@opioid.samhsa.gov.

Uses and Disclosures That Require Your Written Authorization:

We will obtain your written authorization before using or disclosing your health information for purposes other than those described above. Specifically, we will obtain your authorization before using or disclosing:

- Psychotherapy notes (with limited exceptions)
- Health information for marketing purposes
- Health information in a manner that constitutes a sale of PHI

Additionally, with certain limited exceptions, we are not allowed to sell or receive anything of value in exchange for your health information without your written authorization. If you provide us with authorization to use or disclose your health information about you, you may revoke your authorization, in writing, at any time.

However, uses and disclosures made before the revocation of your authorization are not affected by your action and we cannot take back any disclosures we may have already made with your authorization or that may have been made on reliance of your authorization.

Use of unsecure electronic communications.

If you choose to communicate with us via unsecure electronic communications, such as regular email or text message, we may respond to you in the same manner in which the communication was received and to the same email address or account from which you sent your original communication.

In addition, if you provide your email address or cell phone number to a health care provider, we may send you emails or text messages related to appointment reminders, surveys, or other general informational communications. For your convenience, these messages may be sent unencrypted.

Before using or agreeing to use of any unsecure electronic communication to communicate with us, note that there are certain risks, such as interception by others, misaddressed/misdirected messages, shared accounts, messages forwarded to others, or messages stored on unsecured, portable electronic devices.

By choosing to correspond with us via unsecure electronic communication, you are acknowledging and agreeing to accept these risks. Additionally, you should understand that the use of email or other electronic communications is not intended to be a substitute for professional medical advice, diagnosis, or treatment.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and obtain a copy of your health information that may be used to make decisions about your care, including medical and billing records. To inspect or copy your health information, submit a written request to our Privacy Officer. We may charge a reasonable fee for copying and mailing costs.

Scoville Osteopathic Healthcare, P.C.

10325 Lloyd Road / Potomac, MD 20854 / 301-304-3330 / scovilleosteopathichealth.com

Right to Amend. If you believe that information in your record is incorrect or incomplete, you may request that we amend it. To request an amendment, submit a written request to our Privacy Officer that includes the reason for your request. We may deny your request in certain circumstances, and if we do, we will provide you with a written explanation.

Right to an Accounting of Disclosures. You have the right to receive a list of certain disclosures we have made of your health information. To request an accounting, submit a written request to our Privacy Officer specifying the time period for which you want the accounting (not to exceed six years). The first accounting in a 12-month period will be provided free of charge; subsequent requests may incur a reasonable fee.

Right to Request Restrictions. You have the right to request restrictions on how we use or disclose your health information for treatment, payment, or healthcare operations, or to restrict disclosures to family members or others involved in your care. We are not required to agree to your request except in one situation: if you pay for a service or item out of pocket in full, you can ask us not to share information about that service or item with your health insurer for payment or healthcare operations purposes, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. To request confidential communications, submit a written request to our Privacy Officer specifying how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices at any time. You may also obtain a copy of this Notice by visiting <https://www.scovilleosteopathichealth.com/patient-forms-1> or by contacting our Privacy Officer at the address provided at the end of this Notice.

Right to Be Notified of a Breach. You have the right to be notified in the event that we discover a breach of your unsecured health information. Right to a Paper Copy of this Notice.

Changes to the Terms of This Notice.

We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, in our facility, and on our web site.

Complaints.

If you have any questions about this Notice or our privacy practices, or if you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address and phone number below. You will not be retaliated against for filing a complaint. you wish to exercise your HIPAA rights or make a complaint, please contact our Privacy Officer.

Contact Information

Privacy Officer: Katherine J. Scoville, D.O.

Address: 10325 Lloyd Road, Potomac, MD 20854

Phone: 301-304-3330

Email: info@scovilleosteopathichealth.com

To File a Complaint with HHS:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, D.C. 20201

Phone: 1-877-696-6775

Website: www.hhs.gov/ocr/privacy/hipaa/complaints/

Office Policy

Welcome:

To help you get acquainted with the office, we have prepared this statement about our policies and fee schedules. Please sign below to indicate that you have read and understand our guidelines.

Office Hours:

In Potomac: Mondays 1-8:30pm; Tuesdays 8:30am-4:30pm; Wednesdays 9am-5pm; Fridays 10am-4pm
or at *8609 Second Avenue, Suite 405B, Silver Spring, MD 20910:* Thursdays 12:30-8:30pm

Your Appointment:

Your appointment is time set aside for you to see the Doctor. We have a **twenty-four (24) hour cancellation policy**. If you cancel an appointment less than 24 hours prior to its scheduled time, you will be billed the full visit fee. A message may be left on our voice mail at any time to cancel your appointment. The earlier you can inform us of a change in your plans, the more efficient use we can make of our time. We also respect your time and will make every effort to be punctual for your appointment.

Children:

Children *must be supervised by their caretaker and remain in the waiting area* unless they are being seen by the doctor.

Fragrances:

Some of our patients are allergic to environmental pollutants such as perfumes and hair sprays; we would appreciate it if you would refrain from wearing these to the office.

Fees & Payments:

For all patients, we require payment for services at the time they are provided. We do not participate with private insurance carriers, but we supply a standard, itemized receipt that you may submit to your non-Medicare insurance company to request reimbursement. Our practice also does not participate with Medicare or Medicaid. Because Dr. Scoville has opted out of Medicare, Medicare patients will need to sign a Private Pay Contract, which the doctor will explain prior to treatment. The Contract affirms that the patient accepts responsibility for all treatment costs, and will not seek Medicare reimbursement.

The parent or guardian of a minor patient is responsible for payment.

Checks returned from the bank will incur a \$30.00 "returned check" fee to your account.

Thank you for taking the time to read this policy sheet. If you have any questions about our policy please ask them now.

Name: _____

HISTORY OF CURRENT ISSUE

1. What problems cause you to consult the doctor today? (Describe your symptoms in detail.)

2. When did your symptoms begin? _____

3. Do you know what caused them? If so please explain. _____

4. If you have pain, has it increased or decreased since the onset? _____

5. What has helped relieve your symptoms? _____

6. What time of day are your symptoms most severe? _____

7. How many days a week do you experience your symptoms? _____

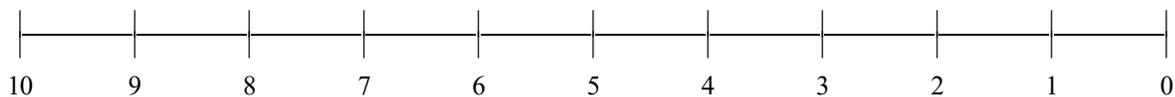
8. What type of treatment, medical or non-medical, have you received for this problem? _____

9. How has this pain affected your life, at work, at home, and socially? _____

TO WHAT EXTENT DOES PAIN OR PROBLEM AFFECT YOUR ABILITY TO DO THE FOLLOWING ACTIVITIES:

| Activity | 0% | 25% | 50% | 75% | 100% | Activity | 0% | 25% | 50% | 75% | 100% |
|----------------------------------|----|-----|-----|-----|------|-------------------------------|----|-----|-----|-----|------|
| Shampoo your hair | | | | | | Stand | | | | | |
| Fasten buttons | | | | | | Sleep | | | | | |
| Put on and tie shoes | | | | | | Socialize | | | | | |
| Cut toe nails | | | | | | Travel in a car | | | | | |
| Lift objects less than 20 pounds | | | | | | Fulfill your job requirements | | | | | |
| Walk for > 15 minutes | | | | | | Do laundry | | | | | |
| Sit in a car | | | | | | Shop for groceries | | | | | |
| Lie down in bed | | | | | | Gardening | | | | | |

If "10" = worst and "0" = no problem, on the scale below where would you rate yourself today?:



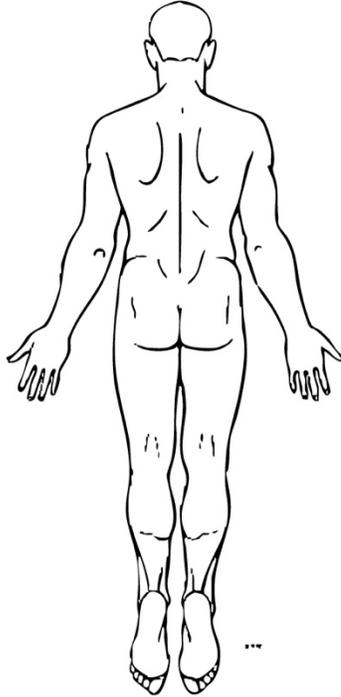
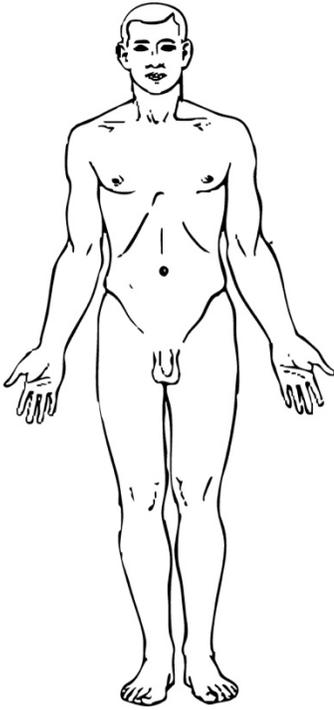
Scoville Osteopathic Healthcare, P.C.

10325 Lloyd Road / Potomac, MD 20854 / 301-304-3330 / scovilleosteopathichealth.com

Name: _____

LOCATE YOUR PAIN ON THE FIGURES BELOW, USING THE SYMBOLS GIVEN BELOW:

| | | | | | |
|--------|----------|----------------|---------|----------|-------|
| Aching | Numbness | Pins & Needles | Burning | Stabbing | Other |
| ^^^ | === | ooo | xxx | /// | +++ |



SOCIAL HISTORY

| |
|---|
| Highest education level: |
| Occupation: |
| Military service: Yes No If yes, where? |
| Travel: (Type and frequency) |
| Hobbies: |
| Exercise program: |
| Alcohol Consumption: Amount per week and years used? |
| Drug use: (Marijuana, Heroin, LSD, Cocaine, Methamphetamine): Amount and how long used? |
| Tobacco use: How much per day and how many years used? |
| Caffeine consumption: (coffee, tea, carbonated soft drink, energy drinks) How many ounces per day? |

Name: _____

PATIENT MEDICAL HISTORY

PAST MEDICAL ISSUES: _____

MEDICATIONS YOU ARE CURRENTLY TAKING: (prescription and over the counter)

| Name | Dosage | Frequency | Years Used |
|------|--------|-----------|------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

Please use back of page if needed.

| ALLERGIES TO: | What symptoms did you have with the reactions? |
|---|--|
| 1. Drugs: | |
| | |
| | |
| 2. Foods: | |
| | |
| 3. Chemicals and Environmental Factors: | |
| | |
| 4. Animals: | |
| | |

OPERATIONS AND/OR ILLNESSES REQUIRING HOSPITALIZATION:

_____ Year _____
 _____ Year _____
 _____ Year _____

INJURIES (severe sprains, fractures, dislocations) OR BONE/JOINT PROBLEMS:

_____ Year _____
 _____ Year _____
 _____ Year _____

RECENT RELEVANT STUDIES OR TESTS:

_____ Year _____
 _____ Year _____
 _____ Year _____

OTHER HEALTHCARE PROVIDERS:

_____ Specialty _____
 _____ Specialty _____
 _____ Specialty _____

IF FEMALE, ARE YOU PREGNANT NOW? _____

Scoville Osteopathic Healthcare, P.C.

10325 Lloyd Road / Potomac, MD 20854 / 301-304-3330 / scovilleosteopathichealth.com

Name: _____

FAMILY HISTORY

Please indicate which of your family members have had: Allergies, Bleeding Tendencies, Cancer (give location and type), Diabetes, Epilepsy, Heart Disease, High Blood Pressure, Kidney Disease, Mental Illness, Lung Disease, Stroke, or Tuberculosis.

| Relative | Age if Living | Health Problem | Age of Onset | Age of Death | Cause of Death |
|-------------|---------------|----------------|--------------|--------------|----------------|
| Paternal GM | | | | | |
| Paternal GF | | | | | |
| Maternal GM | | | | | |
| Maternal GF | | | | | |
| Father | | | | | |
| Mother | | | | | |
| Brothers | | | | | |
| | | | | | |
| Sisters | | | | | |
| | | | | | |
| Children | | | | | |
| | | | | | |

REVIEW OF SYSTEMS

Indicate "C" if it is a current problem and "P" if it is a past problem

| C | P | 1. SKIN: | C | P | 3. HEAD: | C | P | 4. EYES: (continued) |
|---|---|------------------------------|---|---|------------------------------------|---|---|---------------------------|
| | | Color change | | | Trauma | | | Color blindness |
| | | Texture change | | | Headache | | | Glaucoma |
| | | Moisture Change | | | Dizziness or light-headed | | | Cataracts |
| | | Sores | | | Fainting | | | Wear glasses/contacts |
| | | Itching | | | Loss of consciousness | | | Date of last refraction |
| | | Severe acne | | | Feeling of spinning | C | P | 5. Ears (R or L or Both?) |
| | | Cancer | | | Seizure disorder | | | Hearing loss |
| | | Easy bruising/bleeding | C | P | 4. EYES (R or L or Both?) | | | Use of hearing aid(s) |
| | | Change in Fingernails | | | Itching | | | ringing in ears |
| | | Hair loss/distribution | | | Watering or dryness | | | Ear pain |
| | | Oiliness (skin, hair, scalp) | | | Discharge or crusting | | | Discharge |
| C | P | 2. LYMPHNODES: (B or L?) | | | Double vision | | | Excess wax |
| | | Enlargement | | | Sensitive to light | | | Recurrent infections |
| | | Redness (inflammation) | | | See halos around light or floaters | | | Mastoiditis |
| | | Pain or tenderness | | | Change in vision | | | Motion sickness |

Name: _____

REVIEW OF SYSTEMS (cont.)

| C | P | 6. NOSE: | C | P | 9. CARDIOVASCULAR | C | P | 11. GASTROINTESTINAL (cont.) |
|----------|----------|--------------------------------|----------|----------|-------------------------------------|----------|----------|--|
| | | Trauma | | | Blood clots in the lungs | | | Bowel movements during night |
| | | Sinusitis | | | High blood pressure | | | Constipation |
| | | Excess nasal drainage | | | Chest pressure or tightness | | | Straining with bowel movements |
| | | Stuffiness | | | Chest pain or heaviness | | | Diarrhea |
| | | Obstruction | | | Chest discomfort (exertional) | | | Use of antacids or laxatives |
| | | Post-nasal drainage | | | Palpitations | | | Black stools |
| | | Nosebleed | | | Rapid heart rate at rest | | | Grey or yellow stools |
| | | Smell (decrease or loss of) | | | Irregular heart rate | | | Rectal pain or discomfort |
| | | Mouth breather | | | Heart murmur | | | Rectal itching |
| | | Frequent colds | | | Swollen ankles/feet in evening | | | Hemorrhoids |
| | | Snoring | | | Leg cramps when sleeping | | | Rectal bleeding |
| C | P | 7. MOUTH / THROAT/ NECK | | | High cholesterol or fats | | | Anal Fissures |
| | | Trauma | | | Blue hands or feet | | | Hernia (umbilical or hiatal) |
| | | Sores in mouth | | | Calf pain while walking | | | Yellow skin (jaundice) |
| | | Bleeding or infected gums | | | Cold hands or feet | | | Gall stones or GB disease |
| | | Sore tongue | C | P | 10. BREASTS (R or L or both) | | | Pancreatitis |
| | | Dental cavities | | | Pain and tenderness | C | P | 12. URINARY TRACT: |
| | | Frequent sore throats | | | Swelling | | | Difficulty / inability to urinate |
| | | Difficulty swallowing | | | Lumps or masses | | | Infrequent, sm. Amt. of urine |
| | | Persistent hoarseness | | | Nipple retraction | | | Frequent urinary tract infections |
| | | Change of taste | | | Nipple discharge or bleeding | | | Flank pain |
| | | Bad breath | | | Frequency of self-examination | | | Kidney infection / nephritis |
| | | Big tonsils / adenoids | C | P | 11. GASTROINTESTINAL | | | Kidney or bladder stones |
| | | Thyroid enlargement | | | Wt. loss/gain in the last year | | | Hernia: L or R inguinal or femoral |
| | | Neck pain or tenderness | | | Loss of appetite | | | Sexually transmitted disease |
| C | P | 8. RESPIRATORY | | | Compulsive eater | | | Sexual problems you wish to Discuss with the doctor? |
| | | Asthma | | | Stomach / duodenal ulcers | | | Frequent urination |
| | | Pneumonia | | | Heartburn | | | No. of times you urinate at night |
| | | Bronchitis | | | Indigestion | | | Cloudy urine |
| | | Emphysema | | | Food intolerances | | | Dribbling |
| | | Cough | | | Bloating or belching | | | Urgency / loss of control |
| | | Sputum (amount and color) | | | Flatulence (passing gas) | | | Hesitancy |
| | | Cough up blood | | | Nausea | | | |
| | | Shortness of breath (@ rest) | | | Vomiting | | | |
| | | Shortness of breath (exertion) | | | Vomiting blood | | | |

Name: _____

REVIEW OF SYSTEMS (cont.)

| C | P | 19. OB / GYNECOLOGY: | C | P | 14. MALE GENITALIA (cont.) | C | P | 16. PSYCHOLOGICAL (cont.) |
|---|---|---|---|---|---|---|---|----------------------------------|
| | | When was the first day of Your last period? | | | Sexual dysfunction or impotence | | | Problems (with spouse / family) |
| | | At what age did you have Your first menstrual period? | | | Testicular mass (R or L?) | | | Previous psychiatric care |
| | | How many days do you Flow? | | | Decreased force of urinary stream | | | Do you desire psychiatric care? |
| | | Menstrual cramps | | | Difficulty starting or Stopping flow of urine | | | Cry often |
| | | Hot flashes | C | P | 15. NEUROLOGICAL: | | | Worrier |
| | | Painful intercourse | | | Head injury | | | Perfectionist |
| | | Vaginal discharge | | | Frequent headaches | C | P | 17. MUSCULOSKELETAL |
| | | Vaginal dryness | | | Loss of consciousness | | | Trauma (fracture / dislocation) |
| | | Sores on external genitalia | | | Fainting | | | Car accident |
| | | Infertility problems | | | Numbness (location?) | | | Decreased range of motion |
| | | Breast feeding | | | Tingling (location?) | | | Loss of strength |
| | | Contraceptive use: (type?) | | | Weakness (location?) | | | Stiff or aching muscles / joints |
| | | No. of pregnancies | | | Tremors | | | Neck ache / pain |
| | | No. of live births | | | Convulsions | | | Backache / pain |
| | | No. of living children | | | Twitching | | | Arm or hand pain |
| | | No. of abortions (miscarriages) | | | Difficulty walking | | | Numbness / tingling (where?) |
| | | Complications (with pregnancies or deliveries) | | | Speech abnormalities | | | Sciatic pain (R or L?) |
| C | P | 14. MALE GENITALIA: | | | Decrease / loss of sensation | | | Arthritis |
| | | Urethral discharge | C | P | Sleep disturbances | | | Swollen joints |
| | | Sores on penis or scrotum | | | 16. PSYCHOLOGICAL | | | Join pain |
| | | Testicles tender (R or L?) | | | Nervousness / anxious | | | Blow to the head |
| | | Enlarged prostate | | | Sensitive | | | A fall on your buttocks? |
| | | Prostatitis | | | Depressed | | | |
| | | Elevated PSA | | | Fatigue | | | |
| | | | | | Memory change | | | |

For Physician's use:

| |
|--|
| |
| |
| |
| |
| |
| |
| |
| |