Eastport Health Care, Inc.
Our Specialty is YOU!

Rowland B. French Medical Center
Vogl Behavioral Health Center
30 Boynton Street
Eastport, Maine 04631
Phone: 207-853-6001
Fax: 207-853-6180

Welcome to EHC!

Thank you for your interest in becoming our patient! Our goal is to provide high quality health care and we are excited to be your Patient Centered Medical Home.

Please complete and return the enclosed documents to our office to begin the process of becoming our patient. All forms must be filled out as completely as possible. Missing documents or incomplete forms will be sent back to you which will delay your initial appointment.

1. Registration form
2. Authorization to Release Health Information form (This is required for us to request past medical records. Our providers must review past medical records before deciding if they are able to accept you as a patient.)
3. Health History form

This process could take anywhere between 3-6 weeks to obtain all of the necessary information and present it to a provider. Once we receive all of the necessary information, a provider has 7 business days to review your information. If one of our providers can provide your care, our reception staff will contact you to schedule an initial appointment. In the event a provider is not able to provide your care, we will provide you with information for other local medical providers.

If you have any questions or concerns, please contact us at any of our office locations.

Machias Behavioral Health
160 Dublin St.
Machias, ME 04654
Phone: (207)-255-3400
Fax: (207)-255-3401

Machias Family Practice
160 Dublin St.
Machias, ME 04654
Phone: (207)-255-8290
Fax: (207)-255-4109

Machias Pediatrics
160 Dublin St.
Machias, ME 04654
Phone: (207)-255-0980
Fax: (207)-255-3897

Kulasihkulpon peciyayin EHC! (Passamaquoddy)

Woliwon eli-tpitahatomon kiseltomuwinen ktankeyulonen! Npawatomonen kulankeyulonen, naka nulitahasipon eli yut-oc kil ktaspihtolom.

Mec-op-al kisi-psonehtun naka ktapaciptun ntahpisomonnuk yuhtol wikhikonol, weci-kisi-mace luhkatomek eli-koti-mace-ankeyuwulek. Psi-te pilaskul cuwi-'kihka-psonehtasuwol.

Keskahtasikil pilaskul naka wikhikonol skat nekka-psonehtasinuhk cu-oc wesuwe-pcitahkewkenol, nakahc amsqahs keti-nemiyukiyin-oc metsiyewiw.

Nehehtaw iyyin qecikesuwakonol kosona 'tomitahasuwakonol, mec-op-al kisi-mattoktehmuwinen tan-ote ehtek ntahpisomonnul.

Bienvenue chez EHC ! (French)

Merci de vouloir devenir l'un de nos patients ! Notre objectif est de fournir des soins de santé de haute qualité et nous sommes heureux d'être votre maison médicale centrée sur le patient.

Veuillez remplir et renvoyer les documents ci-joints à notre bureau afin d'entamer votre procédure d'inscription en tant que patient. Tous les formulaires doivent être remplis aussi complètement que possible. Les documents manquants ou les formulaires incomplets vous seront renvoyés, ce qui retardera votre rendez-vous initial.

1. Formulaire d'inscription
2. Formulaire d'autorisation de divulgation de renseignements médicaux. (Nous en avons besoin pour demander des antécédents médicaux. Nos prestataires doivent examiner vos antécédents médicaux avant de décider s'ils sont en mesure de vous accepter en tant que patient.)
3. Formulaire de l'historique de santé.

Lorsque nous aurons reçu toutes les informations nécessaires, un prestataire dispose de 7 jours ouvrables pour examiner vos informations. Si vous êtes accepté comme patient, notre personnel d'accueil vous contactera pour fixer un premier rendez-vous. Dans le cas où un prestataire ne serait pas en mesure de vous accepter en tant que patient, nous vous fournirons des informations pour d'autres prestataires médicaux locaux.

Eastport Health Care Inc.
Patient Registration Form
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Current Patient Information (Please Print)				
Last Name:		First Name:	Middle Name:	Preferred Name:
Street Address	PO Box		City	State Zip
Home Phone: Primary __Y __N		Cell Phone: Primary __Y __N	Work Phone:	Email: (see below)
Would you like to sign up for our patient portal? ____Yes (please list email above) ____Declined				
Date of Birth:	Marital Status:	Social Security #:	Gender:	Primary Caregiver:
Guarantor Name:		Guarantor Address:		Guarantor Phone:
Relationship to Patient:		Social Security #:	Date of Birth:	
Emergency Contact:		Relationship to Patient:	Home Phone:	Cell Phone:

Medical Insurance Information			
Primary Medical Insurance Name	Policy #	Group#	Employer Name
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder
Secondary Medical Insurance Name	Policy #	Group#	Employer Name
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder

Dental Insurance Information			
Primary Dental Insurance Name	Policy #	Group#	Employer Name
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder
Secondary Dental Insurance Name	Policy #	Group#	Employer Name
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder

Notice of Privacy Practice, Consent, and Assignment of Benefits	**Payment and No Show Policy**
I hereby assign my insurance benefits to be paid directly to the Provider. I authorize the Provider to release any medical/dental information required to process claims. I authorize my Provider's office to contact me by telephone to remind me of my appointment. I acknowledge that I have reviewed the Consent for Medical and Dental Treatment, the Notice of Privacy Practices, and Patient Centered partnership of Care patient rights forms. By signing below I acknowlege that I have read and agree to the statements listed above and any questions or concerns I have were addressed. **Patient/Parent/Guarantor/Authorized Representative Signature:**	Quality Care for our patients is our priority. EHC has developed a Payment Policy and No Show Policy to assist you in understanding your financial obligations and the impact on our practice when a patient "no-shows". By signing below, I acknowledge that I have reviewed, understand, and agree to adhere to the policies. **Patient/Parent/Guarantor/Authorized Rep. Signature:**
Date:	Date:

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Eastport Health Care, Inc. is a Federally Qualified Health Center funded by the Bureau of Primary Health Care. As a requirement for funding, we are responsible for collecting the following data on all of our patients. If you choose not to share this data, please indicate by checking "declined".

Annual income: _$_____ ☐ per year ☐ per month ☐ every two weeks ☐ weekly ☐ Declined

Number of Household Members: _____ ☐ Declined

Agricultural Worker: ☐ Migrant ☐ Seasonal ☐ No ☐ Declined

School-Based Health Center Patient: ☐ Yes ☐ No ☐ Declined

Name of School: _____

Homeless Status: ☐ Yes ☐ No ☐ Declined **Veteran Status:** ☐ Yes ☐ No ☐ Declined

Public Housing Patient: ☐ Yes ☐ No ☐ Declined **Preferred Language:** ☐ English ☐ Other ☐ Declined

Race: ☐ African American ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Other Race ☐ White ☐ Declined

Ethnicity: ☐ Central American ☐ Cuban ☐ Dominican ☐ Hispanic or Latino/Spanish ☐ Latin American/Latin, Latino ☐ Mexican ☐ Non-Hispanic or Latino ☐ Puerto Rican ☐ South American ☐ Spaniard ☐ Declined

Sex: ☐ Male ☐ Female ☐ Chose not to disclose

Patient Name: _____

Signature: _____ **Date:** _____
Patient/Parent/Guarantor/Authorized Representative

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CONSENT FOR TREATMENT AT EASTPORT HEALTH CARE

1. I am aware that the practice of medicine/dentistry is not an exact science and that EHC offers no guarantee concerning any treatments or examinations that I may have here.

2. I understand EHC and its employees may use the information contained in my record for proper medical/dental purposes, and for clinical improvement audits.

3. I authorize the medical/dental staff at EHC to conduct any diagnostic examinations, test and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for a particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.

4. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

SIGNATURE: By signing below I acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

_____ _____

Patient/Authorized Representative* Signature Date

*If signed by an Authorized Representative

_____ _____

Printed name of Authorized Representative Source of Authority (e.g., guardian, Power of attorney)

Eastport Health Care Inc.-
Behavioral Health Departments - Medical Records
30 Boynton Street - Eastport, Maine 04631
160 Dublin Street - Machias, Maine 04654
Tel#(207)853-0185 or 207-255- 3400 Fax (207)853-4028

Patient Name:

Patient Former Name or Alias:

Patient Address:

Date of Birth:

Patient Phone:

Authorization to Release Health Information

I give my permission for EHC (Eastport Health Care) and its employees to:

☐ **Get** My Medical Information indicated below **FROM** ***OR*** ☐ **Send** My Medical Information indicated below **TO**

Name of Person or Organization: _____

City/State/Zip: _____

Phone: _____ Fax: _____

To be ☐ Mailed ☐ Faxed ☐ Emailed (if requesting secure electronic delivery) _____
Email Address

Dates of Care or Dates of Records

☐ **All Records** _____ (**Note:** check "All Records" ONLY if all medical records are needed. Sensitive Medical Information is not included unless selected below.)

OR I wish to release **Only those items selected below:**

☐ Clinic Records _____ ☐ Immunization Records _____

☐ Lab Reports _____ ☐ Hospital Records _____

☐ Radiology Reports _____ ☐ Summary Records _____

☐ Other Records _____

Sensitive Medical Information (Substance Abuse, Mental Health, HIV/AIDS): THIS SECTION MUST BE COMPLETED

I understand what may happen if I release the following sensitive information and have indicated which items I do wish to release and/or those I do not wish to release below. Consent to release these records may include all information unless I specify specific dates below.

☐ **I DO** / ☐ **I DO NOT** wish to release HIV/AIDS records _____

☐ **I DO** / ☐ **I DO NOT** wish to release Mental Health Treatment records _____

☐ **I DO** / ☐ **I DO NOT** wish to release Substance Use Disorder Treatment records _____

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I authorize the release of the Sensitive Medical Information selected above without review UNLESS I initial here _____.

The purpose of the disclosure is (check where applicable):

☐ Coordination of Medical Care ☐ Transfer of Medical Care ☐ Insurance ☐ Legal ☐ Disability ☐ School Entry ☐ Referral

☐ For Personal Use, please explain _____ ☐ Other, specify _____

Other Instructions: _____
Please use this space to indicate any special requests, information you do not wish disclosed, a different event or expiration for this Authorization, or any other instructions which may assist us with your request.

This Authorization is for ☐ a one-time disclosure OR ☐ multiple disclosures (Note: authorization for disclosure of certain mental health records cannot be continuing authorizations)

This Authorization expires: _____ Note: If left blank, this form will expire in ninety (90) days for one-time disclosures or in (1) year for multiple disclosures of health records. **Exception:** Six (6) months for children in residential and foster care.

Eastport Health Care Inc. -
Behavioral Health Department
Medical Records
Tel:(207) 853-0185 or 207-255-3400
Fax (207) 853-4028

Patient Name:

Date of Birth:

This Authorization Form is voluntary and you may refuse to sign it. You may also cross out any words on this form that you do not agree with. Refusal to sign the form will not block your ability to receive health care services or payment for services; except that refusing to sign will mean you will not receive health services if those services are only to provide your Medical Information to someone else which requires a signed Authorization form. Refusal to sign this form may cause improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other negative outcomes. I understand that certain health information I authorize to be disclosed may be subject to redisclosure by the recipient and no longer protected.

You may have a copy of this form if you wish. In addition, you have the right to review the records before they are sent. You also have the right to receive a copy of the information requested in this form. Patients may receive a personal copy of these records at no charge, while a fee will be assessed for third party requests. The current prices are available where you receive care or by calling Medical Records at (207) 853-6001. The requested information will be sent within thirty (30) days of when you submit a completed form and pay any required fee.

- If you ask that copies of the requested information be sent by mail, EHC may send that information on a compact disc unless you have given other instructions.
- If you ask for e-mail copies of the information, you must provide a valid e-mail address. Your records will be given as Adobe PDF files via EHC's secure messaging method. EHC will send an email to the email address you provide with instructions on how to access your medical Information.

You can revoke this authorization at any time by sending a written request to the person or entity that is sending us the records, or to us if we are the ones releasing your records to an outside entity or person. If you cancel this Authorization, it will not stop or change any action already taken by EHC or any other entity named in this release that was taken in reliance on this authorization and prior to receiving your notice to cancel. Canceling this form can cause denial of health benefits or other insurance coverage benefits.

I have read this Authorization form and I understand it. By signing below, I give my permission for EHC to release the Medical Information as described in this form and I release EHC, its employees, directors, officers and medical staff, from legal responsibility or liability for the release of the Medical Information.

Signed: _____ Date: _____
(Patient or Representative)

Print Name: _____

If not signed by the Patient, please indicate the authority to act for the patient: ☐ Parent ☐ Guardian ☐ Power of Attorney
[*Please attached proof of authority if signing as a guardian or under a power of attorney.]*

FOR OFFICE USE ONLY

Notice to Recipient of Prohibition on Redisclosure

Each disclosure made with the patient's written consent must be accompanied by the written statement reproduced below: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice Regarding Sensitive Medical Information

For persons/organizations receiving mental health information or HIV provided by EHC: This information has been disclosed to you from records protected by State confidentiality laws (22 M.R.S.A. § 1711-C(6)(A)(2) and/or 5 M.R.S.A. § 19201 *et seq.*). This information remains confidential and should not be disclosed any further except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

EHC Use Only: Received By: _____ Location: _____ Date: _____
Rev. 4/27/2018

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EHC Patient Portal Access and Consent

Eastport Health Care is pleased to offer established patients access to our online Patient Portal managed by Athenahealth, our electronic health record platform. The patient portal is a secure way to access your health information, contact your provider with questions, request refills, view appointments, view or pay your EHC bill and much more! Please read and sign below to request access or give permission to a family member/caretaker to access.

Important: By signing below, you understand that your patient portal contains personal health information including, but not limited to: diagnosis information, medication lists, allergy lists, past medical history information, visit summaries, mental health information, billing information, and appointment information. Eastport Health Care is not responsible for the misuse, unauthorized disclosure, or other use of information obtained by yourself or person you have given permission to through the patient portal. You are responsible for the creation and privacy of your portal password. Minor patients under the age of 13 do not have the ability to create a patient portal account. If requested, it will be created for the use of parents/legal guardians. Patients 18 and over must provide written permission for family members, caretakers, or others to have access to their patient portal. Permission may be revoked by the patient at any time by contacting Eastport Health Care.

Our patient portal may be accessed at: https://8309.portal.athenahealth.com or through the patient portal log-in link on our webpage: www.eastporthealth.org.

Patients Name: _____ Date of Birth: _____

____ Yes, please sign me up for the portal!

Email address: _____

____ I am the parent/legal guardian of the minor child above and wish to have access to their patient portal.

Parent/Guardian Name: _____

Email address: _____

____ I authorize access of my patient portal to:

Name: _____ Relationship: _____

Email address: _____

Signature: _____ Date: _____

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Authorization for Portal Communication

You may be contacted via text, email, or automated phone call for appointment reminders, health reminders, notification of a new bill, a new message from your provider, etc. Please use the spaces below to authorize consent to each of the three methods of contact.

Consent to text: ____ Yes ____ No

Consent to email: ____ Yes ____ No

Consent to call: ____ Yes ____ No

Pediatric Medical Health History Form

This form will help your clinician better understand you or your child's medical concerns and conditions. If you are uncomfortable with any question, do not answer it.
Please provide your best guess when a date is requested.

Name: _____Date of Birth: _____Today's Date: _____
Name of Person Completing this form: _____ Relationship to Patient: _____
Preferred Provider: _____ Preferred Pharmacy: _____

MEDICATIONS *(Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, oxygen, CPAP)*

Medication and Dose	Instructions	Medication and Dose	Instructions

ALLERGIES *(Medicines, Seasonal, Environmental, Foods)*

Allergy	Reaction	Allergy	Reaction

PERSONAL MEDICAL HISTORY
Please list any medical problem(s), hospitalizations, surgeries, serious illnesses, or accidents you have ever had.

History	Date

Please make a check mark next to any of the below developmental concerns.

Concern	Yes	Concern	Yes
Physical Development		School Experience	
Behavior		Bathroom/Toilet Habits	
Eating Habits		Discipline	
Sleeping Habits		Other *	

**Other problems, please specify:* _____
If you have ever had a blood transfusion, please specify date(s) _____
Would a blood transfusion be acceptable in an emergency? ____No ____Yes
Do you have any religious or spiritual beliefs? ____No ____Yes
Last Dental Exam? _____ Last Eye Exam? _____

BIRTH HISTORY
Birth Weight: _____ Birth Length: _____ Place of Birth: _____
Length of stay at the hospital after birth: _____

Pediatric Medical Health History Form

Please make a check mark if the mother experienced any of the following conditions during the pregnancy.

Condition	Yes	Condition	Yes
High Blood Pressure		Alcohol Use	
Diabetes		Substance Use	
Bleeding/Clotting Disorder		Tobacco Use	
Depression		Other *	

**Other problems, please specify:* _____

FAMILY HISTORY

Please list any biological family members that have ever had any of the following conditions.

Condition	Family Member	Condition	Family Member
Alcoholism/Substance Abuse		COPD	
Anemia		Heart disease/Heart attack	
Anxiety		Heart Failure	
Asthma		Heart Valve problems	
Cancer (type)		High blood pressure	
Depression		Kidney disease	
Diabetes (type)		Stroke	
Seizures		Other*	

**Other problems, please specify:* _____

Does the child have consistent child-care (baby-sitter, pre-school, day care)? _____

Please list all people in the household and any siblings (including those that may have passed away).

Name	Relationship	Date of Birth

HEALTH MAINTENANCE

Please enter the date of your most recent immunizations and tests.

Flu _____ Pneumonia _____ Tetanus _____ HPV _____

Hepatitis A _____ Hepatitis B _____ Measles _____ Mumps_____ Rubella_____

MMR _____ Varicella (chicken pox) _____ PPD _____

SOCIAL HISTORY (This section is for teenagers and is to be completed by the patient)

Tobacco/Alcohol/Drug Use

Do you smoke? ____ No ____Yes Current Smoker: ____packs/day _____ # of years

Do you use any of the following? ___ Pipe ___ Cigar ___ Snuff ___ Chew ___ E-cigarettes/Vape

Do you drink alcohol? _____ No _____ Yes, # drinks/week_____

Do you use any street drugs? ____ No ____ Yes, *please specify:* _____

Have you ever used street drugs? ____ No ____ Yes, *please specify:* _____

Pediatric Medical Health History Form

Have you ever injected street drugs? _____ No _____ Yes, *please specify:* _____

Diet/Exercise

meat servings per day: _____ # fresh fruit/vegetable servings per day: _____

of snacks per day: _____ # sweetened beverages per day: ____ # caffeinated beverages per day: _____

Do you exercise regularly? _____ No _____ Yes, *please specify*: _____

SOCIOECONOMICS (This section is for teenagers and is to be completed by the patient)

Are you currently employed? ____ No _____ Yes Occupation: _____

Education completed: _____

Marital status: ____Single ____M ____Sep ____D ____W ____Cohabitating

Spouse/Partner's name: _____ Number of children: _____

WOMEN'S GYNECOLOGIC HISTORY (This section is for teenagers and should be completed by the patient)

pregnancies: ____ # deliveries: ____ # miscarriages: ____ # abortions: _____ Age at first childbirth: ____

1st day, most recent period: _____ Age at 1st period: ____ Frequency of periods: _____

Length of each period: _____ Do you have any concerns about your periods? ___ No ___ Yes

Ever had an abnormal PAP? ____ No ___ Yes: results _____

SEXUALITY (This section is for teenagers and should be completed by the patient)

Sexually Active: ____ Yes ____ No

Current sex partner(s) is/are: ___ male ___ female

If sexually active, do you practice safe sex (use condoms)? _____ NA ____ No _____ Yes

Have you ever had any sexually transmitted diseases (STDs)? ____ No ____ Yes

If yes, please specify: _____date_____

Are you interested in being screened for sexually transmitted diseases? ____ No ____ Yes

Ever been exposed to HIV/AIDS? _____ No _____ Yes

Have you been tested for HIV? _____ No _____Yes: results _____

Would you like to be tested for HIV? _____ No _____ Yes

Other concerns? _____

SAFETY (This section is for teenagers and should be completed by the patient)

Do use seatbelts consistently? ___ No ___ Yes

Do you have a smoke detector in your home? ___ No ___ Yes

Is violence at home a concern for you? ____ No ____ Yes

Do you feel safe in your current relationship? ____ N/A ____ No ____ Yes

Do you have a gun in your home? ____ No ____ Yes

Do you use a bike helmet regularly? ___ N/A ____ No ____ Yes

Other concerns? _____

EMOTIONS (This section is for teenagers and should be completed by the patient)

During the past month, have you often been bothered by feeling down, depressed, or hopeless?

____ No ____ Yes

During the past month, have you often been bothered by little interest or pleasure in doing things?

____ No ____ Yes

Pediatric Medical Health History Form

REVIEW OF SYSTEMS

Please make a check mark next to any symptoms you have had in the last couple of days:

Constitutional		**Respiratory**	
Unintended Weight Loss		Cough	
Unintended Weight Gain		Shortness of breath or difficulty breathing	
Poor Appetite		Wheezing	
Fever		Coughing up sputum	
Chills		Coughing up blood	
No Energy		Chest tightness	
Eyes		**Gastrointestinal**	
Pain		Difficulty swallowing	
Blurry vision		Abdominal pain	
Double Vision		Heartburn	
Redness		Nausea	
Itchiness		Vomiting	
Swelling		Diarrhea	
Discharge		Blood in stool	
Ears, Nose, Throat		Mucus in stool	
Ear Pain		Change in bowel habits	
Discharge		Loss of bowel control	
Hearing Loss		**Genitourinary**	
Ringing in the ears		Discharge	
Sinus Pressure		Blood in urine	
Drooling		Pain with urination	
Facial Swelling		Increased frequency or urgency	
Sore Throat		Urinary loss of control	
Mouth Lesions		Flank pain	
Dental Pain		Testicular pain or swelling	
Swollen Glands		Redness	
Cardiovascular		Itchiness	
Swelling		Masses/lumps	
Chest Pain		**Musculoskeletal**	
Shortness of breath with activity		Soft tissue swelling	
Heart Palpitations (heart racing or fluttering)		Muscle pain	
Breasts		Moves arms and legs well	
Lumps		Localized joint pain	
Tenderness		Previous injuries	
Discharge		Spine pain	
		Pain radiating down arms	
		Pain radiating down legs	
		Weakness in arms	
		Weakness in legs	

Pediatric Medical Health History Form

Skin		**Female Health**	
Pain		Irregular Menses	
Itching		Non-menstrual Bleeding	
Dryness/Flaking		Menopausal Symptoms	
Redness		Hot Flashes	
Rash/Hives		Night Sweats	
Growths/Lumps		Dry Vaginal Mucosa	
Swelling		Change in Libido (sex drive)	
Bruising		Orgasmic Dysfunction	
Insect Bites		Difficult or Painful Intercourse	
Lesions		Vaginal Tightening	
Neuro		**Male Health**	
Numbness		Change in Libido	
Weakness		Difficulty with Intercourse	
Tingling		Impotence	
Burning		**Allergic/Immunologic**	
Shooting Pain		Seasonal Allergies	
Headache		Sneezing	
Dizziness		Runny Nose	
Trouble finding words or forgetting words		Food Allergy	
Speech Difficulties		Contact Dermatitis (allergic skin rash)	
Poor Coordination			
Loss of Consciousness			
Arm or hand weakness			
Difficulty Emptying Bladder			
Change in Bowel Habits			
Psychiatric			
Decreased Functioning Ability			
Depression			
Anxiety			
Insomnia			
Stress			
Loss of Interest			

Please feel free to make any additional comments for any symptoms you are experiencing or any concerns you may have and would like to discuss at your initial appointment:

_____
_____
_____
_____
_____