

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

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.

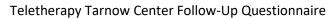
Name:	Appointment Date:				
Email:	Phone:				
Date of Birth:	Your Name if parent or guardian:				
* PLEASE PROVIDE 2 BLOOD I	PRESSURE/PULSE IF HIGHER TH	HAN USUAL			
Blood Pressure:	Pulse:	Ht	Wt		
Date/Time Taken:					
Blood Pressure:	Pulse:	Date/Time Ta	ken:	-	
Please List any Allergies:				☐ None	
All Current Medications medications):	(please list prescription			the counter	
Medication:	Dose in mg:	How Ofte	en:		
Medication:	Dose in mg:	How Ofte	en:		
Medication:	Dose in mg:	How Ofte	en:		
Medication:	Dose in mg:	How Ofte	en:		
Medication:	Dose in mg:	How Ofte	en:		
Medication:	Dose in mg:	How Ofte	en:		
Other:	Dose in mg:	How Ofte	en:		



Other:	_ Dose in mg:	How Often:
Other:	_ Dose in mg:	How Often:
Reaction to Medications: Yes No If	Yes, explain:	
Current Pharmacy: Name: Location:		Phone:
Significant Changes:		
Rate changes in symptoms overall since last a More Severe Much Worse No Cha		
Please choose an item for each sy choose no change)	mptom listed	d below. If the item does not apply
Mood/Behavior		Physical
Anxiety	,	Weight
\square Increased \square Decreased \square No Change		\square Increased \square Decreased \square No Change
Anger	1	Appetite
☐ Increased ☐ Decreased ☐ No Change		☐ Increased ☐ Decreased ☐ No Change
Depression	!	Headaches
☐ Increased ☐ Decreased ☐ No Change		☐ Increased ☐ Decreased ☐ No Change
Hyperactivity	1	njury to Self
☐ Increased ☐ Decreased ☐ No Change		☐ Increased ☐ Decreased ☐ None
Impulsivity		Other
☐ Increased ☐ Decreased ☐ No Change	1	\square Increased \square Decreased \square No Change



Productivity	Sleep
Concentration	Sleep Quality
☐ Increased ☐ Decreased ☐ No Change	☐ Normal/Refreshing ☐ Restless ☐ Delayed Onset
	☐ Nightmares ☐ Oversleeps
Attention	Sleep Alone
☐ Increased ☐ Decreased ☐ No Change	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	1
Current Medical Problems since last visit: Heart Problems: Yes □ No -If yes, explain: Stomach Problems:	
☐ Yes ☐ No -If yes, explain:	
-ii yes, explaiii	
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? No If yes, who:
Contact (Email/Phone) Information:
Any Other Concerns or New Developments since your last visit?: