

PLEASE FILL OUT THIS FORM FOR ANY / ALL AREAS YOU ARE WANTING YOUR DOCTOR TO TREAT AND DISCUSS IN TODAY'S VISIT

1st Area of Concern:						
Using a scale from 0-10 (10 being the wors	st), how w	ould yo	ou rate	your c	ondition?	
	l 5	6	7	8	9	10
Describe what symptoms you are experie	encing:					
How often do you experience your sympto	oms?					
Constantly (76-100% of the time)	□ Int	ermitte	ntly (26	6-50%	of the t	time)
Frequently (51-75% of the time)	\square Occasionally (1-25% of the time)					ne)
2nd Area of Concern:						_
Using a scale from 0-10 (10 being the wors						
(Please circle) 0 1 2 3 4		6	7	8	9	10
Describe what symptoms you are experie	encing.					
How often do you experience your sympto	oms?					
Constantly (76-100% of the time)	Intermittently (26-50% of the time)					
\square Frequently (51-75% of the time)	\square Occasionally (1-25% of the time)					
3rd Area of Concern:						
Using a scale from 0-10 (10 being the wors						
(Please circle) 0 1 2 3 4 Describe what symptoms you are experie		6	7	8	9	10
How often do you experience your sympton $=$ Constantly (76, 100%) of the time)		ormitto	nthy (26	E 00/	of tha t	ime)
 Constantly (76-100% of the time) Frequently (51-75% of the time) 	 Intermittently (26-50% of the time) Occasionally (1-25% of the time) 					
		casion	any (1-	23 /0 01		ne)
QUESTIONS REGARDING YOUR TREAT	MENT: (L	se the	back if	neede	d)	
				· · · · · ·	· · · · · ·	· · · · · · ·
			· · · · · · ·			
Signature:	Date:					