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

Patient's Name (Printed): ______________________________

1st Area of Concern: ____

Using a scale from 0-10 (10 being the worst), how would you **rate** your condition?

(Please circle) 0 1 2 3 4 5 6 7 8 9 10

Describe what **symptoms** you are experiencing:

____

____

How **often** do you experience your symptoms?

- ☐ Constantly (76-100% of the time)
- ☐ Intermittently (26-50% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Occasionally (1-25% of the time)

2nd Area of Concern:____

Using a scale from 0-10 (10 being the worst), how would you **rate** your condition?

(Please circle) 0 1 2 3 4 5 6 7 8 9 10

Describe what **symptoms** you are experiencing:

____

____

How **often** do you experience your symptoms?

- ☐ Constantly (76-100% of the time)
- ☐ Intermittently (26-50% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Occasionally (1-25% of the time)

3rd Area of Concern:____

Using a scale from 0-10 (10 being the worst), how would you **rate** your condition?

(Please circle) 0 1 2 3 4 5 6 7 8 9 10

Describe what **symptoms** you are experiencing:

____

____

How **often** do you experience your symptoms?

- ☐ Constantly (76-100% of the time)
- ☐ Intermittently (26-50% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Occasionally (1-25% of the time)

QUESTIONS REGARDING YOUR TREATMENT: (Use the back if needed)

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Signature:______________________________ **Date**: ____________________