Welcome to Pfeiffer Treatment Center! Helping people is our commitment. We hope this informational sheet will assist you in understanding whom PTC cares for, and what you can expect from visiting our Center or a PTC Outreach Clinic.

Who are our patients?

Pfeiffer patients from around the world come to our Center or a PTC Outreach Clinic seeking a clinical and healthy treatment for their symptoms caused by a biochemical imbalance. Individuals may also choose to visit PTC (main clinical headquarters only) to support their health and wellness in the absence of symptoms of a biochemical imbalance.

Symptoms of a possible biochemical imbalance include:

- Anxiety and panic attacks
- Hyperactivity or behavior problems
- Trouble staying focused or difficulty with concentrating
- Frequent mood changes
- Developmental delays
- Depression.

Many have been previously diagnosed with: ***attention deficit disorder (ADD), attention deficit disorder with hyperactivity (ADHD), dyslexia, autism spectrum disorder (ASD), anxiety, depression, postpartum depression, post traumatic stress syndrome, bipolar disorder, schizophrenia, and beginning stages of Alzheimer's disease and Parkinson disease.***

What can I expect?

Pfeiffer's caring medical team takes an integrative approach by involving physicians, registered nurses, dieticians, pharmacists and other medical/clinical specialists. The PTC clinical team conducts a biochemical assessment of each patient. Once a person's individual biochemistry is identified, a custom treatment may be prescribed.

A typical visit and evaluation at the Pfeiffer Treatment Center or a PTC Outreach Clinic includes:

- An interview with a registered nurse to discuss medical and relevant health history
- A physical examination and consultation with a physician or physician assistant.
- Laboratory analyses of blood, urine, and hair.

The Pfeiffer medical practitioner reviews this information to determine the patient's chemical imbalance and develops an individualized nutrient program of vitamins, minerals and amino acids to address the patient's unique biochemical needs.

How does our treatment work with other therapies?

Pfeiffer's biochemical therapy is not an alternative to traditional drug therapies or counseling, but a complement to them. Patients must seek the professional guidance and advice from their primary care physician/psychiatrist for any changes to their psychiatric medications or doses.

Over, please

Our mission is to normalize biochemistry in children and adults through research, development, education, and affordable clinical services.

Since 1989, Pfeiffer Treatment Center (PTC) has helped more than 22,000 patients from all 50 states and from more than 75 countries at our Centers in Warrenville, Illinois (clinical headquarters), and Oakdale, Minnesota, or at our Outreach Clinics in Arizona, northern and southern California, Maryland and Michigan. Health Research Institute – the research and development arm of the Pfeiffer organization – engages in ongoing research to refine our ability to diagnose and treat biochemical imbalances. Research studies are published regularly and in nationally and internationally acclaimed scientific journals. Our medical and research professionals are dedicated to helping our patients lead productive and rewarding lives.

FINANCIAL INFORMATION

The evaluation process at PTC emphasizes the uniqueness of each patient, while providing cost-effective and affordable care. Therefore, the services provided and the tests ordered depend on the complexity of the patient's symptoms, as well as the professional judgment of your assigned PTC medical practitioner.

Fees are based upon the services provided, the tests ordered, the complexity of the medical decision-making process, and the time that is required to develop an effective, individualized treatment program. There is an additional fee for our Outreach Clinics.

INSURANCE COVERAGE: PTC does not accept assignment or participate in Medicare, Medicaid, Tricare or any insurance plans. However, since we are committed to accurate and compliant coding of our services, the majority of our patients with insurance do typically receive some level of reimbursement.

At the end of the visit, the patient receives a patient bill of services that can be submitted to their insurance provider for reimbursement. Our insurance support representative is also able to provide assistance with answering any questions or handling requests from the patient's insurance provider. An insurance packet, which includes a schedule of fees, diagnostic codes, and other appropriate information, is available by calling 630.505.0300 or 866.504.6076.

PAYMENT INFORMATION: Payment is due at the conclusion of each visit. The average cost of the initial visit is $1000-$1300. This includes all the testing, a visit with the doctor and nurse and a results telephone consult with the nurse when you receive your results. We accept cash, check, money order, traveler's check, MasterCard and Visa. For a telephone consultation, payment by credit card (MasterCard or Visa) is also due at the time of service. If a patient is unable to pay by credit card, previous arrangements need to be made prior to the telephone consultation. Patients visiting any one of our Outreach Clinics must make a non-refundable deposit to schedule and secure appointments.

Pfeiffer Treatment Center

Please submit the completed Health History Form by mailing / faxing to:

For those patients who will be seen at our Warrenville, IL Center, Judson Center in Royal Oak, MI or any of our Outreach Clinics:

Pfeiffer Treatment Center
4575 Weaver Parkway
Warrenville, IL 60555-4039
Phone: 630-505-0300
Fax: 630-836-0667

For those patients who will be seen at our Oakdale Minnesota Center:

Pfeiffer Treatment Center
Oakdale Square
6230 10th Street North, Suite 310-A
Oakdale, MN 55128
Phone: 651-209-9282
Fax: 651-209-9283

Electronic Communication: If you would like to use email communication, please provide your email address. Please note that we cannot send private medical information by email due to privacy concerns. If the patient is a minor, please list the email address of the parent/legal guardian.

Email Address: ____________________@______________________ ☐ Patient ☐ Parent/Guardian

I prefer email communication for:

- ☐ Appointment Reminders
- ☐ General announcements of new or updated services, programs, and research from Marketing.

How did you hear about Pfeiffer Treatment Center?

☐ Family Member ☐ Friend

☐ Postcard ☐ Flier / Brochure

☐ Internet - *if so*:

- ☐ Pfeiffer Treatment Center website (www.hriptc.org)
- ☐ Other website: ____-______________

☐ Presentation/Informational Seminar *(Location/Date)*: ________________________________

☐ Conference *(Location/Date)*: ____

☐ Trade Show Booth *(Location/Date)*: ____

☐ Print or Broadcast Media *(please provide details)*: __________________________________

☐ Book / Resource *(please provide title)*:____

☐ Other:____

☐ Professional Referral *(please provide specific information on the next page)*

HEALTH HISTORY FORM

PATIENT INFORMATION

*** Required Information**

*NAME: ______________________________________
Last First M.I.

*ADDRESS: ______________________________________
Number Street Apt.

____
City State Zip Code

*Complete the parent information **only** if the patient is a minor*

Mother's Name: ______________________

Father's Name: _______________________ *or*

Legal Guardian's Name:________________________

*DATE OF BIRTH (DOB): _____/_____/_________

GENDER: ☐ Male ☐ Female

AGE: ________ WEIGHT: ________ lbs.

Is the patient a minor? ☐ Yes ☐ No

*PHONE: (____) _____-________
(if different than guarantor)

Does the Patient have:

*Federal Medicare ☐ Yes ☐ No

Federal Tricare Insurance ☐ Yes ☐ No

State Medicare ☐ Yes ☐ No

EMERGENCY CONTACTS

1. NAME: ____________________________________
   PHONE: (____) _____-________
   ☐ Parent ☐ Legal Guardian ☐ Spouse
   ☐ Other: _______________________
2. NAME: ____________________________________
   PHONE: (____) _____-________
   ☐ Parent ☐ Legal Guardian ☐ Spouse
   ☐ Other: _______________________

GUARANTOR INFORMATION

*NAME: ______________________________________

*ADDRESS: ______________________________________
Number Street Apt.

____
City State Zip code

EMAIL: ___________________@__________________

☐ Parent ☐ Legal Guardian ☐ Spouse
☐ Other: _______________________
Home: (______) _______-_________
Work (______) _______-_________
Cell: (______) _______-_________
*SS # _____-________-________
*DOB # _____/______/______

*Employer: ____________________________

*Employer Address: ______________________

____

*Employer Phone: (_____) ______-_________

PROFESSIONAL REFERRAL:

NAME: _____________________________

PROF. TITLE:________________________

Address:_____________________________

____

Phone: (______) _______-____________

FINANCIAL RESPONSIBILITY: I under that all professional services are charged to the patient, and are due and payable on the date that services are rendered unless other arrangements have been made with the financial counselor. I agree to pay all such charges in full immediately upon presentation of the appropriate statement.

Guarantor's Signature ____ DATE: _____________________________

PTC Pfeiffer Treatment Center

HEALTH HISTORY FORM

CURRENT MEDICATIONS AND SUPPLEMENTS (two pages)

Please read the instructions carefully:

1. List all **recent or current** prescriptions *(Rx)* and over the counter *(OTC)* medications and supplements.
2. It is very important to know the total amount of certain nutrients when interpreting lab results and developing your program. For those supplements that have more than one ingredient,
   Attach a list of ingredients with amounts or a copy of the label.

MEDICINE/SUPPLEMENT	DOSE	WHEN TAKEN	DATE STARTED	LAST TAKEN	REASON / RESPONSE	D/C'd *(ofc. use)*
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						

Please total the amount of zinc in all supplements taken in a usual day. **TOTAL DAILY ZINC: ______________**

Patient Name: ____ DOB: ____/____/______

ALLERGIES/REACTIONS TO MEDICATIONS/SUPPLEMENTS:
List all medications and supplements to which you have adverse reactions and the type of reaction.

ALLERGIES / REACTIONS TO FOOD PRODUCTS:
List all foods and additives to which you have adverse reactions and the type of reaction.

☐ Corn ☐ Soy ☐ Wheat ☐ Gluten ☐ Dairy ☐ Egg
☐ Rice ☐ Sugar ☐ Fish ☐ Citrus ☐ Other: ________________

List any products *(e.g. corn or soy)* that you do not want as part of the nutrient program:

MEDICATION FAILURES:
List all medications that have not had any beneficial effect or which had an effect other than anticipated:

Is the patient on a special diet? ☐ Yes ☐ No
☐ Casein Free ☐ Specific Carbohydrate Diet ☐ Feingold Diet
☐ Gluten Free ☐ Body Ecology Diet
☐ Other

Can the patient swallow pills? ☐ Yes ☐ No

Are you interested in compounding *(combining of nutrients in capsules where possible)* ☐ Yes ☐ No

Antihistamines or Inhalers in the last 3 months? ☐ Yes ☐ No When? ___________

Antibiotics in the last 3 months? ☐ Yes ☐ No When? ___________

Allergy shots or drops in the last 3 months? ☐ Yes ☐ No When? ___________

Swimming pool use in the last 3 months? ☐ Yes ☐ No How often? _______

Hair treatment (color, perm) in the last 3 months? ☐ Yes ☐ No When? ___________

List all current therapies *(OT, PT, Speech, ABA, RDI, etc.)*:

Office Use Only:

Patient Name: ____ DOB: ____/____/______

PTC Pfeiffer Treatment Center

HEALTH HISTORY FORM

Name Patient Prefers: ____________________

Patient Medical History (check if applicable)

☞ *In the Past - or*
⇩ ☞ *Current Problem*

☐ ☐ Acne
☐ ☐ Eczema
☐ ☐ Psoriasis

☐ ☐ Allergic Rhinitis
☐ ☐ Chronic Sinusitis
☐ ☐ Asthma
☐ ☐ Arthritis/Rheumatoid/Lupus
☐ ☐ Chronic Fatigue Syndrome
☐ ☐ Multiple Sclerosis
☐ ☐ Collagen Vascular Disease
☐ ☐ Fibromyalgia
☐ ☐ Multiple Chemical Sensitivities

☐ ☐ Heart Disease
☐ ☐ Stroke
☐ ☐ Hypertension
☐ ☐ High Cholesterol/High Triglycerides
☐ ☐ Diabetes
☐ ☐ Cancer

☞ *In the Past - or*
⇩ ☞ *Current Problem*

☐ ☐ Esophagitis
☐ ☐ Peptic Ulcer Disease
☐ ☐ Gastro Esophageal Reflux
☐ ☐ Pancreatitis
☐ ☐ Colitis
☐ ☐ Irritable Bowel Syndrome
☐ ☐ Inflammatory Bowel Disease
☐ ☐ Gall Bladder Dysfunction

☐ ☐ Hepatitis
☐ ☐ Liver Disease
☐ ☐ Kidney Problems
☐ ☐ Urinary Tract Infections
☐ ☐ Benign Prostatic Hypertrophy

☐ ☐ Thrush
☐ ☐ Athlete's Foot
☐ ☐ Toe Nail Fungus/Fingernail
☐ ☐ Ring Worm
☐ ☐ Yeast Infections

☞ *In the Past - or*
⇩ ☞ *Current Problem*

☐ ☐ Hypothyroidism
☐ ☐ Hyperthyroidism

☐ ☐ Alzheimer's Disease
☐ ☐ Parkinson's Disease
☐ ☐ Dementia
☐ ☐ Seizure Disorder

☐ ☐ Fibrocystic Breast Cancer
☐ ☐ Endometriosis
☐ ☐ Fibroid Tumors
☐ ☐ Polycystic Ovarian Disease
☐ ☐ PMS
☐ ☐ Postpartum Depression
☐ ☐ Menopause

☐ ☐ Glaucoma
☐ ☐ Night-Blindness
☐ ☐ Other: ____________________

Psychiatric History

☞ *Diagnosed - or*
⇩ ☞ *Symptoms or Suspected*

☐ ☐ ADD
☐ ☐ ADHD
☐ ☐ Learning Disability
☐ ☐ PDD/Autism spectrum
☐ ☐ Oppositional Defiant Disorder
☐ ☐ Conduct Disorder
☐ ☐ Behavior Disorder
☐ ☐ Tics/Tourettes

Eating Disorders
☐ ☐ Anorexia Nervosa
☐ ☐ Bulimia Nervosa
☐ ☐ PICA
☐ ☐ Obesity

☞ Diagnosed - or
⇩ ☞ *Symptoms or Suspected*

Anxiety Disorders
☐ ☐ Generalized Anxiety Disorder
☐ ☐ Phobic Disorder
☐ ☐ Panic Disorder
☐ ☐ Obsessive Compulsive Disorder
☐ ☐ Post Traumatic Stress Disorder
☐ ☐ Acute Stress Disorder

Mood Disorders
☐ ☐ Major Depressive Disorder
☐ ☐ Bipolar I Disorder
☐ ☐ Bipolar II Disorder
☐ ☐ Dysthymic Disorder
☐ ☐ Cyclothymic Disorder

☞ *Diagnosed - or*
⇩ ☞ *Symptoms or Suspected*

Psychotic Disorders
☐ ☐ Schizophrenia
☐ ☐ Schizoaffective Disorders
☐ ☐ - Bipolar Type
☐ ☐ - Depressive Type
☐ ☐ Delusional Disorder

☐ ☐ Dissociative Disorder
☐ ☐ Dissociative Identity Disorder
☐ ☐ Dissociative Fugue Disorder

Other
☐ ☐ ________________________
☐ ☐ ________________________

Family History *(Please indicate relatives using the key below. Other relatives may be listed if believed significant/relevant.)*
{ FORMCHECKBOX } Patient is adopted, information is not available.

ADD/ADHD	_________	Thyroid	_________	Bipolar	_________	Arthritis	_________
Violence	_________	Ulcers	_________	Alcohol/Drug Abuse	_________	Diabetes	_________
Panic Attacks	_________	Heart Disease	_________	Suicide Attempt	_________	Kidney Problems	_________
Asthma	_________	Stroke	_________	Depression	_________	Cancer	_________
Early Senility	_________	Hypertension	_________	Schizophrenia	_________	Psoriasis	_________

KEY: **M** =Mother **MGM** = Maternal Grandmother **MGF** = Maternal Grandfather **MA/MU** = Maternal Aunt/Uncle **S** =Sister
F = Father **PGM** = Paternal Grandmother **PGF** = Paternal Grandfather **PA/PU** = Paternal Aunt/Uncle **B** =Brother

Other: ____

Chief Complaint: *List the symptoms or problems you would like the Pfeiffer Treatment Center to address:*

Check any of the following symptoms that you currently have:
☐ Fatigue ☐ Nervousness ☐ Anxiety ☐ Irritability / Anger
☐ Obsessions ☐ Compulsions ☐ Depression ☐ Inability to focus / concentrate
☐ Delusions ☐ Mania ☐ Hallucinations
☐ Disordered Thoughts ☐ Other:

How would you describe your temper?

When very angry, how long does it take you to cool off?

Describe your typical reaction to stress:

Significant patient birth events *(premature, low birth weight, C-section, fetal distress, cord around neck, etc.)*:

Head injuries *(including concussions, give approximate date or age, and if there was loss of consciousness/LOC)*:

Surgeries *(type of surgery and approximate date or age)*:

Other hospitalizations *(reason and approximate date or age)*:

Are you pregnant? ☐ Yes ☐ No ☐ N/A
Are you breastfeeding? ☐ Yes ☐ No ☐ N/A

How many alcoholic drinks do you consume? _________ per day / week / month
Describe any illegal drug use in the last year:

Use this space to add additional information:

Office Use Only:

Patient Name: ____ DOB: ____/____/______

HEALTH HISTORY FORM

Physical Health
*Please note current or recent **(last 3 mo.)** problems in the following areas:*

Skin / Hair:

Digestive / GI:

Heart / Circulatory / Cholesterol:

Respiratory:

Endocrine *(thyroid, diabetes, etc.):*

Liver:

Kidney / Urinary:

Neurologic:

Reproductive *(females, see below):*

Immune *(cancer, Lupus, AIDS, ALS, etc.):*

Sensory *(vision, hearing, taste, smell, touch):*

Notes:

Office use only

Female History
Age at first period _____
Number of pregnancies: ____ Miscarriages/abortions: ____ Births: _____

- ☐ PMS
- ☐ Post Partum Depression
- ☐ Ovarian cysts
- ☐ Irregular Periods
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Menopause
- ☐ Fibrocystic Breast Cancer
- ☐ Other:

Patient Name: ____ DOB: ____/____/______

Office use only

Diet: ☐ Regular ☐ Casein Free ☐ Gluten Free ☐ Vegetarian
☐ Feingold ☐ Body Ecology ☐ Specific Carbohydrate
☐ Other:

Number of meals per day: _______ Number of snacks: ________

Appetite:

Cravings:

Rate the intake of the foods below *(circle)*

Sweets	Low	Avg.	High	Carbohydrates[1]	Low	Avg.	High
Protein	Low	Avg.	High	Fruit	Low	Avg.	High
Dairy	Low	Avg.	High	Vegetables	Low	Avg.	High

Main Beverage: _______________ Amount per day: _________________

Caffeine: _______ per day/week ☐ Hypoglycemic symptoms[2]

☐ Pica[3] ☐ Aversion to breakfast ☐ Picky eater

Notes:

Bowel movements / Stooling

Frequency: _____ per ________

Character of stools:

☐ Constipation ☐ Diarrhea ☐ Encopresis[4] ☐ Excess gas

☐ Stomach aches ☐ Posturing

Gut Treatment *(tests done, dates, treatment ordered, and effectiveness):*

Immune Function

Immunizations up to date? ☐ Yes ☐ No

Reactions/Regressions related to immunizations:

☐ Frequent colds/infections ☐ Environmental allergies/rhinitis

☐ Chemical Sensitivities ☐ Other:

Sleep

Difficulty: ☐ Falling asleep ☐ Staying asleep ☐ Waking

☐ Nightmares Dream recall: ☐ None ☐ Dull ☐ Vivid

☐ Enuresis[5] ☐ Other:

[1] Simple carbohydrates such as bread, pasta, breakfast cereals, etc.
[2] Drowsy after meals, shakiness/dizziness, irritability when hungry, craving sweets, etc.
[3] An abnormal craving or appetite for nonfood substances, such as dirt, paint, or clay.
[4] Accidental soiling of undergarments
[5] Bedwetting

Office use only

Cognitive / Executive Functions

☐ Problem staying on task ☐ Impulsivity ☐ Problems with memory
☐ Poor organization ☐ Sequencing[6] ☐ Foggy brained
☐ Hyper behavior / fidgety ☐ Distractible ☐ Racing thoughts
☐ Problems with focus / concentration ☐ Loses things frequently

Motivation: ☐ None ☐ Low ☐ Normal ☐ High

Highest grade completed:

Performance / Grades:

Learning Disabilities (LD) identified:

Accommodations:

Employment: ☐ Full time ☐ Part time Position: ________________
Time there: ________ ☐ Student ☐ Homemaker ☐ N/A
☐ Retired ☐ Disabled ☐ Unemployed

Sensory:
Sensitivities: ☐ Light ☐ Sound ☐ Odors ☐ Tactile *(clothing)*
☐ Ringing in the ears
☐ Upper body pain[7] ☐ Back pain ☐ Joint pain
☐ Headaches Type: ☐ Tension/muscle ☐ Migraine
Pain tolerance: ☐ High ☐ Avg. ☐ Low

Social Development
Lives with whom *(include ages)* ?

☐ Seeks Interaction ☐ Isolates ☐ Alienates ☐ Makes poor choices
☐ Parallel play ☐ Poor eye contact ☐ Divergent Gaze
☐ Misses social cues
☐ Prefers younger playmates ☐ Prefers older playmates

Notes:

Personality and Behavior: *Briefly describe:*

[6] Problems putting things in order, planning
[7] Brain, face, neck, shoulder

Patient Name: ____ DOB: ____/____/______

Brain Health

Developmental disorders:

☐ ADD / ADHD ☐ Autism / Spectrum ☐ PDD ☐ MR

☐ Other:

Anger Management *(give frequency)*:

☐ Argues ☐ Verbal tantrums ☐ Destroys property

☐ Threats ☐ Aggressive to others ☐ Intentional harm

Behavior: ☐ Oppositional Defiant ☐ Self Harm Behaviors[8]:

Anxiety disorders[9]:

Depressive Disorders:

Suicide Risk

☐ History of Attempt ☐ Safety plan in place[10] ☐ Family/Friend History

Check box below if happened in the past. ***Circle if current.***

☐ Thoughts ☐ Plan ☐ Preparation[11] ☐ Intent

This is SERIOUS! If you can circle Plan, Preparation or Intent, contact your family / friend / mental health professional immediately, or call 911.

Dementia / degenerative disorders:

Eating disorders:

Mood Disorders:

Psychotic disorders:

☐ Hallucinations: ☐ Auditory ☐ Visual ☐ Tactile

☐ Disordered Thoughts ☐ Delusions ☐ Other:

Seizure disorders:

Tics / Tourette's:

☐ Clumsiness / accident prone

Office use only

[8] Cutting, burning, etc.

[9] Include OCD, Panic Disorders

[10] A Safety Plan is an arrangement you make with your healthcare provider, family or friend(s) to keep you safe when experiencing recurrent or ongoing suicidal thoughts.

[11] Obtaining lethal measures, contacting financial/legal professionals, giving things away, writing a note, etc.

Office use only

DEVELOPMENTAL ADDENDUM

Complete this section only for developmental disorders such as Autism Spectrum Disorders (ASD), Pervasive (and other) Developmental Disorders, etc.

Mother's health during pregnancy

Mother's age at patient's birth: ______

Dental work:

RhoGam:

Immunizations:

Note type, amount and frequency

Alcohol use:

Tobacco use:

Illicit drug use:

Medications:

Mood disorders:

☐ High blood pressure / Preeclampsia ☐ Toxemia ☐ Gestational diabetes

Preterm labor @ ____ weeks

Neonatal Health

☐ Low birth weight – Birth weight: _____lbs. _____ oz.

Birth events: ☐ Cord around neck ☐ Emergency C-section

☐ Forceps use ☐ Vacuum use ☐ Fetal distress

☐ Preterm delivery @ ____ weeks ☐ Other delivery problems:

☐ Jaundice ☐ Oxygen after birth ☐ Ear infections ☐ Colic

☐ Antibiotics ☐ Formula intolerance

☐ Skin problems:

Potential toxic exposures

☐ Home built before 1978

☐ Second hand smoke

☐ Parent or family occupation[12] / hobby[13]:

☐ Immunizations (note reaction or regression)

Water source[14]:

[12] Work with lead or other heavy metals, Lead/brass/bronze melting/ refining/ manufacturing, Rubber/plastic manufacturing, Painting, Demolition, Construction, Battery manufacture/recycling, Radiator manufacturing/repair, Soldering, Steel welding/cutting

[13] Glazed pottery, Stained glass, Painting, Firearms (shooting, reloading), Lead figurines, Antique toys, etc.

[14] Note if bottled, tap, well, filtered, softened, tested

Developmental History

Gross motor development:

Fine motor development:

Sensory Integration:

☐ Repetitive behaviors:

☐ Disruptive behaviors:

Plays with toys appropriately? ☐ Yes ☐ No

Language development ☐ Early ☐ Normal ☐ Late

☐ Regressed – at what age? ______

Language functioning: ☐ None ☐ Words ☐ Sentences

☐ Repetitive ☐ Processing deficits ☐ Echolalia ☐ Scripting

☐ Able to understand / follow directions

Notes:

Other: *Please note anything of concern not entered above, or give additional information if needed.*

Office use only

Patient Name: ____

DOB: ____/____/______

Problem List *(office use only)*: Indicate severity of each problem using a 1 (mild) – 10 (severe) rating scale.		
No.	**Severity (1-10)**	**Description:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Recommendations:

Notes to Practitioner:

Signatures:

Nurse: ________________________________ Date: ______________

Practitioner: ________________________________ Date: ______________

Patient Name: ____________________________________ DOB: ____/____/______