

Dr. _____ Appt: _____

PATIENT REGISTRATION

Acct# _____

PATIENT INFORMATION

1. Patient Name: _____
 (Last) (First) (Middle Initial) (Nickname)
2. Address: _____
 (City) (State) (Zip) Apt.# _____
3. Home Phone: () _____ 4. Work Phone: () _____ Ext.#: _____ Cell () _____
5. Soc.Sec #: _____ 6. Sex M F 7. Marital Status: S M D W 8. Birthdate: _____ Age: _____
9. Email: _____ Other Contact Numbers: _____
10. Employer: _____ Occupation: _____ 11. Student/School: _____ Full Time ___ Part Time ___
12. If dependent child, are custodial parents: Married _____ Separated _____ Divorced _____ Other _____
13. IN CASE OF EMERGENCY NOTIFY: Name _____ Relationship _____ Address _____
 Phone () _____
14. Primary Care Physician: _____
 (Name) (Address) (Phone)
15. Pharmacy Name and Phone Number: _____

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR) INFORMATION

If same as patient, please complete only questions #1 & #6 of this section

1. Guarantor Name: _____ Birthdate: _____
 (Last) (First) (Middle Initial)
2. Guarantor Address: _____
 (City) (State) (Zip)
3. Guarantor Relationship to Patient (circle one): Spouse Mother Father Sibling Other Relative Friend Other
4. Home Phone: () _____ 5. Soc. Sec. #: _____ 6. Drivers License #: _____
7. Guarantor's Employer: _____ Work Phone () _____ Occupation _____
8. SPECIAL ARRANGEMENTS: _____

DO YOU HAVE INSURANCE*? ___ YES ___ NO (IF YES, PLEASE COMPLETE BELOW)

*Please note: Dr. Henderson does not routinely bill insurance but it is still helpful to have this information on file for future reference.

1. **Primary** Insurance Co. Name: _____ Phone: () _____
 Insurance Co. Address: _____
2. Subscriber's Name: _____ 3. Relation to Pt: Self Spouse Parent Other
 Employer: _____ Wk Ph: () _____ Occupation: _____
4. Birthdate: _____ 5. Group ID #: _____ 6. Soc. Sec. #: _____
7. **Secondary** Insurance Co. Name: _____ Phone: () _____
 Insurance Co. Address: _____
8. Subscriber's Name: _____ 9. Relation to Pt: Self Spouse Parent Other
 Employer: _____ Wk Ph: () _____ Occupation: _____
10. Birthdate: _____ 11. Group ID #: _____ 12. Soc. Sec. #: _____

GUARANTOR AGREEMENT: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Dr. Henderson:

Guarantor Signature (Patient signature, if patient is guarantor) _____ Date _____

PHYSICIAN-PATIENT AGREEMENT & TREATMENT CONSENT

GENERAL: I ask all new patients to carefully read this four-page agreement. It will then become a part of your clinic record.

If you are seeing a therapist, I would appreciate a signed release of information so that I may speak with him/her as needed. Also, if you have current medical problems for which you are seeing a primary care physician or other specialist, I may require a release of information so that I can speak to them also about your care.

I am not involved in worker's compensation cases, disability evaluations, child custody, or other legal matters. Therefore, you will need to be referred to another psychiatrist if the need for testimony and/or reports arises.

APPOINTMENTS AND FEES: After your first visit, I will need to see you within one to four (1 to 4) weeks to review your progress. Thereafter, follow-up appointment frequency will be individualized as appropriate. Office visits are required for my ongoing assessment of your clinical status and treatment needs. I ask that you make every effort to arrange for childcare during appointments.

The length for follow-up appointments may vary, depending on your needs at the time of the appointment. Initial evaluations are usually 50 minutes in length with follow-up appointments between 20-30 minutes. If a longer appointment is needed we can work this out to your specific needs at the time of each appointment. Full payment is due at the time of service. I will provide a billing sheet for you to submit to your insurance company for out-of-network benefits if you so desire. You may also be charged for the time required to complete other paperwork and/or phone calls.

Please be careful to keep track of all your appointments. I will make every effort to call and remind you of your appointment but this is a *courtesy* call. You will be charged the full fee for appointments cancelled without 24 hours notice, and for *missed* appointments as well. I appreciate as much notice of appointment changes as possible as I do not schedule more than one person per appointment time. I do require a credit card number to be kept on file for these kinds of charges. Please see the Missed appointment form.

Multiple missed appointments may result in termination of our doctor - patient relationship.

Late Arrival: If you arrive late for an appointment, I may be able to see you for the remainder of the session, but you will be charged for the fully allotted time. Depending on your arrival time, rescheduling may be necessary. If it is possible to exchange your appointment with another patient, we will make every effort to do so.

PHONE CALLS & EMERGENCIES: If needs arise that cannot wait until your next appointment, leave a message on my voice mail complete with details of your question or concern and I will return your call as soon as possible. If you have an urgent need and CANNOT wait for me to return your call, or are in danger of harming your self, harming someone else, or *being* harmed by someone, go to the nearest hospital emergency room or call 911!

Urgent calls are to be restricted to needs that cannot wait until the next business day. Refills are not considered an emergency and will be handled only during regular business hours.

Successful treatment requires that you attend all scheduled sessions and express your ideas and emotions honestly and openly using verbal communication. Threats or acts of physical harm to me, others or clinic property will result in immediate termination of treatment and notification of the proper authorities.

LAB WORK: I check laboratory values on all of my patients at least yearly, as there are many physiological factors that play a large role in mood and sleep. You can use the laboratory of your choice (**patients with insurance need to find out which laboratories accept their insurance**). The lab will bill you or your insurance company directly. Refusal to follow through with requested lab work is considered medical non-compliance. I obtain random drug screens on all of my patients whether or not drug use is suspected.

CONFIDENTIALITY: Doctor-patient confidentiality is limited under the following circumstances:

1. If a third-party payer (employer, insurance or managed care company, etc.) who is directly or indirectly paying for your care requests information or records.
2. If a legal action is filed in which your mental health is at issue and I am asked or ordered to testify.
3. If malpractice is alleged.
4. If I become aware of abuse or neglect of a child, elder or disabled person, I am obligated to report it to the appropriate authorities.
5. If I determine you are an imminent danger to yourself or others, I must contact a family member and/or the police in an effort to provide for your/others' safety.
6. We cannot respond to any phone calls or correspondence from family members or friends unless we have a signed consent from you.

MEDICATION MANAGEMENT;

In order to provide the best quality of care, treatment is not conducted over the phone unless specifically agreed upon by both myself and you as the patient ahead of time.

THE FOLLOWING REQUIRE AN APPOINTMENT:

1. **New prescriptions and medication refills.**
2. **Any adjustment that needs to be made to your current medication.**
3. **If you are having problems with your medication such as side-effects, or if you feel they are not effective in managing your symptoms.**
4. **If you notice a change in your mood or personality**

I will prescribe enough medication to last until you are to come for a follow-up appointment. Please schedule this appointment before you are to run out of medication. Refills are to be given at this appointment. You must allow 24 hours for any refills.

Please do not lose your written prescriptions. There is a \$15.00 charge for lost scripts that need to be rewritten or called in.

CONTROLLED AND SCHEDULED MEDICATIONS:

Lost or stolen prescriptions for a controlled or scheduled medicine will not be replaced or filled early. These medications are your responsibility and include such medicine as Klonopin, Xanax, Ativan, Valium etc. and ADD medications such as Ritalin, Adderall, Concerta, Vyvanse, Focalin, etc. and sleep aids such as Ambien and Lunesta. This also includes suboxone.

MEDICATION USE PRECAUTIONS: Any medication can impair thinking or reaction time until your body gets accustomed to it. Therefore, do not operate hazardous machinery, including automobiles or do anything potentially dangerous until you are certain any newly prescribed medication(s) do not affect your abilities. It is necessary to notify me and all your other doctors of any and all changes in prescribed and over-the-counter medicines including "herbal/natural" remedies.

Contact me if you experience any unanticipated medication effects including a skin rash, as that indicates a medication allergy. I advise you not to consume alcohol, including beer or illicit drugs, while taking medication, as this will prevent your medications from working optimally and the combination can be physically dangerous. Mixing alcohol and illicit drugs with your medication or taking more than what is prescribed is considered medical non-compliance, which may result in discontinuation of treatment.

If you or someone else takes more than the recommended dose of a medicine, contact poison control, call 911 or go to an emergency room. Do not allow others to take your medicine and do not take medications prescribed for someone else. Keep all medications out of the reach of children and impaired adults.

WOMEN: Please **notify me** of any pregnancy or intent to become pregnant, as most medications should be discontinued prior to conception. Waiting to stop medication until you miss a menstrual cycle and discover you are pregnant exposes your baby to medication during the critical periods of organ development and can lead to birth defects. Whenever possible, psychiatric medications should not be used at any time during pregnancy or while breastfeeding.

REFERRALS: If the need arises for you to be admitted to an inpatient hospital, you will be under the authority of that facility's attending psychiatrist. Most of the time the attending physician will contact me, but I cannot guarantee what he or she will do. Resuming your care upon discharge will be worked out according to your specific needs. As your treating psychiatrist it is my duty to seek your best interest; therefore, I cannot also serve as a consultant or witness in any legal matters and will refer you to another psychiatrist for an objective evaluation if at any time legal reports or testimony is needed. If there is some aspect of your care that we are unable to agree upon, I will need to refer you to another psychiatrist to continue your care.

AGREEMENT: Your signature below indicates that you have carefully read, understand and accept all the terms of this four (4)-page Treatment Agreement and that you are hereby giving your consent for appropriate medical treatment by Dr. Henderson. I will provide you with a copy of this agreement for future reference at your request.

Print your name

Date

Signature

Name _____ Date _____ ID # _____

P S Y C H I A T R I C M E D I C I N E S

ANTI-DEPRESSANTS	MOOD STABILIZERS	ANTI-ANXIETY	MAJOR TRANQUILIZERS	ADHD	SLEEP	PAIN
Celexa	Depakote	Ativan (Lorazepam)	Abilify	Adderall	Ambien	Butalbital
Desyrel	Dilantin	Buspar	Clozaril	Concerta	Restoril	Codeine
Effexor	Gabitril	Klonopin (Clonazepam)	Cogentin	Cylert	Sonata	Darvocet
Elavil	Keppra	Librium	Geodon	Dexadrine	Trazadone	Fiorcet
Lexapro	Lamictal	Neurontin	Haldol	Focalin	Lunesta	Hydrocodone
Luvox	Lithium	Restoril	Loxitane	Metadate CD	Rozerem	Imitrex
Paxil	Phenobarbital	Valium (Diazepam)	Mellaril	Provigil	Ambien CR	Lorcet
Prozac	Tegretol	Vistaril	Navane	Ritalin		Lortab
Remeron	Topamax	Xanax	Prolixin	Strattera		Midrin
Wellbutrin	Trileptal	Others:	Risperdal	Vyvanse		Norco
Zoloft	Lyrica		Seroquel	Others:		Percocet
Cymbalta	Others:		Stelazine			Stadol
Pristiq			Thorazine			Ultracet
Others:			Trilafon			Ultram
			Zyprexa			Vicodin
			Invega			Zomig
			Others:			Zydone

Place a check mark next to any medications you think you may have been on in the past even if it was for a very short time. Then, off to the side please write a one to two word description or phrase describing your experience with the medicine (e.g. "good" "bad" "great" "made me dizzy" "made me sleepy" etc.) Knowing how you responded on certain medication in the past will help us in your treatment.

MEDICATIONS: Please list medications you are currently taking (psychiatric or other) _____

List any Medications you are allergic to: _____

No-Show and Cancellation Agreement

In an effort to provide excellent client services to all of my patients, and to provide the best possible therapeutic environment, it is my policy to require a fee for no-show appointments and cancellations made less than 24 hours in advance of the scheduled appointment.

A fee of \$150 for missed follow-up appointments and \$250 for evaluations will be charged to the following credit card:

___ **Visa** ___ **MasterCard** ___ **American Express** ___ **Discover**

Credit Card # _____

Name as it appears on Card: _____

CVV code: _____ Expiration Date: _____

I, _____, understand and agree that if I do not show up for my scheduled appointment or if I cancel my scheduled appointment with less than 24 hours notice, the above named credit card will be charged for the balance of the appointment.

Signature: _____ Date: _____

Printed Name: _____

Address: _____

City/State/Zip: _____

Daytime phone: _____

David L. Henderson, M.D.
PSYCHOSOCIAL ASSESSMENT
Age 15 and Above

Name: _____

Record# _____

Age: _____ Sex: _____ Date of Birth: _____

Referral Source _____ Address _____

Phone # _____ Fax # _____ Do I have your permission to release information to the referring professional when it is appropriate? Yes _____ No _____

DIRECTIONS: Please answer the following questions as fully as possible.

Problem Assessment:

Present Problem/Stressors: *Please describe the main reason(s) for seeking treatment at this time:*

Symptoms: *Please complete the symptoms Checklist provided in your initial paperwork.*

Suicidal/Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? yes no If yes, how?

Is there a history of suicide in your nuclear and/or extended family? yes no

Have you ever inflicted burns or wounds to yourself? yes no

Are you presently suicidal/homicidal? yes no

Any other risk taking behaviors that you engage in? yes no

If yes, please explain _____

What event(s) in the recent past has/have contributed to your current condition? _____

Describe additional problems you are experiencing. _____

When did these problems develop? _____

Psychiatric History:

Have you ever had any previous outpatient psychiatric treatment? yes no

Places/Dates _____

Have you ever been admitted to the hospital for mental health or addiction issues? yes no

Places/Dates _____

Name of previous doctors and/or therapists _____

Have you ever received a psychiatric diagnosis? yes no

Please explain _____

Please list psychiatric medications that you have taken, past or present. Include dosages, effectiveness, and any side effects (Please attach a separate sheet of paper if necessary):

Date Taken	Medication	Effectiveness	Side-effects/Problems
Ex: 2/2000 – 5/2004	Ex: Cymbalta 30mg once a day	Ex: improved my mood but did not help with my anxiety	I was nauseated all the time.

Medical Information:

Current Medical Problems:

Current Nonpsychiatric medications/supplements:

Past Medical Problems:

Other doctors/clinics seen regularly: _____

Any History of head trauma (describe): _____

Are you allergic to any medications or have you ever had an adverse reaction to medication? yes no

If yes, please list _____

Current Life Stresses: (include anything that is currently stressful for you; examples include relationships, job, school, finances, children)

Substance Abuse History: Describe your current usage, or usage within the past year (includes alcohol, any illegal drugs, caffeine, and tobacco).

<u>Substance</u>	<u>Amount</u>	<u>Frequency</u>	<u>Age of 1st use</u>	<u>Age regular use started</u>	<u>Last use</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please describe any previous experience with drugs or alcohol. _____

Nutrition:

- Do you feel you have balanced, healthy eating patterns? yes no
- Do you have a lot of concerns about your weight and shape? yes no
- Do you often eat out of depression, boredom, anger? yes no
- Do you ever binge eat or fear losing control of your eating? yes no
- Do you ever self-induce vomiting? yes no
- How do you feel about eating with others in a group? _____
- Do you use laxatives, water pills (diuretics), or diet medications to control your weight? yes no
- Do you or others believe you exercise excessively? yes no

Legal History:

Please explain any legal problems you have had past or present:

- Charges as a minor _____
- Charges presently _____
- Arrests (How many) _____
- Incarcerations (How many) _____
- Parole _____
- Convictions (How many) _____
- Probation _____
- Bankruptcy _____
- Civil Suits _____
- Child Custody Problems _____

Developmental History:

- What was your birth order? _____ of _____ children Who primarily raised you? _____
- How would you describe your childhood? Traumatic Painful Uneventful Good Happy
- Were there any unusual or traumatic experiences for you as a child? (Including physical, sexual, or verbal abuse)
- Date Age Event
- _____
- _____
- _____
- _____

Sexual History: (Answer only as much as you feel comfortable)

Age at the time of first sexual experience: _____ Number of sexual partners: _____
Any history of sexually transmitted diseases? _____ History of abortions? _____
History of sexual abuse, molestation or rape? _____
Current Sexual Problems? _____
What is your sexual orientation? Heterosexual Homosexual Bisexual

Family History:

Are there any psychiatric illnesses that run in your family?

Are there any addictive behaviors that run in your family? (ex: drugs, alcohol, sexual, gambling)

Are there any medical problems that run in your family?

Living Arrangements:

Where do you currently live? _____ How long there? _____
With whom are you living? _____

Social Relationships/Support System:

Who can you count on for support? _____

Do you have close friends (outside of family)? _____
What are your hobbies or leisure activities? _____

Marital History (if applicable):

When were you married? _____ Name and age of spouse _____

Previous marriage(s) yes no If yes, date of divorce(s) _____
Any children from this marriage? _____

What is your perception of your current marriage (include communication patterns, problems, sexual relations).

List names and ages of children. How do you get along with each one?

Name	Age	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Financial Situation:

Describe briefly your financial situation. _____

Religious/Cultural Factors:

What is your religious background? _____

Describe the religious atmosphere in your home (past or present): _____

Do you currently attend church, synagogue, or mosque? yes no

Describe your relationship with God: _____

What do you consider to be the role of God in your treatment? _____

Please list any issues (positive or negative) which are important or may have affected you in regard to religion or ethnic/cultural background.

Educational History:

What was school like for you growing up? _____

Highest level achieved _____ What type of grades did you make? _____

Currently in school? yes no If yes, what level? _____

Work Adjustment History:

Describe your current job/career _____

List all of the jobs you have held within the previous five years?

Military History:

List branch, dates, and duties. _____

Miscellaneous:

Are there any other things that can be helpful for us to know about you?

Is there anyone else that it would be appropriate, and you would permit us, to contact in regard to your care?

yes no If yes, please give their name and phone number: _____

What would you like to accomplish during your treatment?

Signature _____

Date _____

Read and Reviewed by _____, **Clinician, on** _____

DAVID L. HENDERSON, M.D.
 8411 Preston Rd. Suite 675 Dallas, TX 75225
 (214) 265-1400 Fax: 265-1425

Name _____ Date _____

Age: _____ Marital Status: _____ Employment Status: _____

Date Symptoms Began: _____ Date Symptoms Worsened: _____

What is your goal for seeking Counseling at this time in your life? _____

SYMPTOM CHECKLIST

- | | | |
|---|---|--|
| <input type="checkbox"/> Depressed or sad Mood | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Nightmares/reliving trauma |
| <input type="checkbox"/> Hard to fall asleep | <input type="checkbox"/> Excessively changing subjects | <input type="checkbox"/> Anxiety about everything in life |
| <input type="checkbox"/> Hard to stay asleep | <input type="checkbox"/> Easily distracted by irrelevant things | <input type="checkbox"/> Fears about body image |
| <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Marked increase in activity level | |
| <input type="checkbox"/> Loss of pleasure in activities | <input type="checkbox"/> Increased energy/hyperactivity | <input type="checkbox"/> Suspiciousness of others |
| <input type="checkbox"/> Lack of motivation/drive | <input type="checkbox"/> Excessive Increase in sex drive | <input type="checkbox"/> Hearing voices others can't hear |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Impulsive risk taking behaviors | <input type="checkbox"/> Seeing visions others can't see |
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Believing that you have special powers | <input type="checkbox"/> Maintaining beliefs that others think are strange |
| <input type="checkbox"/> Poor concentration | | <input type="checkbox"/> Disorganized thoughts |
| <input type="checkbox"/> Appetite/weight loss | | <input type="checkbox"/> Direct messages from TV/radio |
| <input type="checkbox"/> Appetite/weight gain | <input type="checkbox"/> Discrete periods of intense anxiety | |
| <input type="checkbox"/> Feelings of restlessness | <input type="checkbox"/> Heart racing/palpitations | <input type="checkbox"/> Attention/concentration issues |
| <input type="checkbox"/> Feeling lethargic | <input type="checkbox"/> Sweating | <input type="checkbox"/> Impulsive/can't wait turn |
| <input type="checkbox"/> Diminished self-esteem | <input type="checkbox"/> Trembling/shaking | <input type="checkbox"/> Hyperactive/restless |
| <input type="checkbox"/> Hopeless/helpless feelings | <input type="checkbox"/> Feeling short of breath/smothered | <input type="checkbox"/> Can't perform at work/school |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Choking sensation | <input type="checkbox"/> Aggressive/Assaultive |
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Chest pain or discomfort | <input type="checkbox"/> Self-mutilation/Self-harm |
| <input type="checkbox"/> Irritability/short tempered | <input type="checkbox"/> Nausea/stomach distress | <input type="checkbox"/> Chronic Pain |
| | <input type="checkbox"/> Dizziness/faint | <input type="checkbox"/> Daydreaming |
| Suicidal Thoughts? <input type="radio"/> Yes <input type="radio"/> No | <input type="checkbox"/> Feelings of unreality | <input type="checkbox"/> Legal Troubles |
| <input type="checkbox"/> Passing thoughts/no intent | <input type="checkbox"/> Feeling detached from yourself | <input type="checkbox"/> Unexplained body complaints |
| <input type="checkbox"/> Persistent thoughts | <input type="checkbox"/> Fear of losing control/going crazy | |
| <input type="checkbox"/> Current plans/definite intent | <input type="checkbox"/> Fear of dying | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Recent attempt | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Poor judgment |
| <input type="checkbox"/> Past attempts | <input type="checkbox"/> Chills/hot flushes | <input type="checkbox"/> Language/speech difficulties |
| | <input type="checkbox"/> Fear of being in public | <input type="checkbox"/> Impaired intellect/thinking |
| <input type="checkbox"/> Abnormally elevated mood | <input type="checkbox"/> Avoiding places you could not escape | |
| <input type="checkbox"/> Periods of high self-esteem | | <input type="checkbox"/> Pulling hair out |
| <input type="checkbox"/> Periods of grandiose thinking | | <input type="checkbox"/> Anger/Emotional outburst |
| <input type="checkbox"/> Periods of decreased need for sleep | <input type="checkbox"/> Recurrent disturbing thoughts | <input type="checkbox"/> Binge Eating/Purging |
| <input type="checkbox"/> Abnormally talkative | <input type="checkbox"/> Repetitive relieving behaviors | <input type="checkbox"/> Uncontrolled Gambling |
| <input type="checkbox"/> Feeling pressure to keep speaking | <input type="checkbox"/> Ritualized behaviors/obsessions | <input type="checkbox"/> Stealing or Lying |

MEDICAL REVIEW OF SYSTEMS

Please place a check mark in the boxes that apply. Explain any problem areas

General

- Being overweight
- Recent weight gain or weight loss
- Poor appetite
- Increase appetite
- Abnormal sensitivity to cold
- Cold sweats during the day
- Tired or worn-out
- Hot or cold spells
- Abnormal sensitivity to heat
- Excessive sleeping
- Difficulty sleeping
- Lowered resistance to infection
- Flu-like or vague sick feeling
- Sweating excessively at night
- Excessive daytime Sweating
- Excessive thirst
- Other _____

Neurological

- Pacing due to muscle restlessness
- Forgotten periods of time
- Dizziness
- Drowsiness
- Muscle spasms or tremors
- Impaired ability to remember
- "Tics"
- Numbness
- Convulsions/fits
- Slurred speech
- Speech Problem (other)
- Weakness in muscles
- Other _____

Respiratory

- Asthma, wheezing
- Cough
- Coughing up blood or spasm
- Shortness of breath
- Rapid breathing
- Repeated nose or chest colds
- Other _____

Chest and Cardiovascular

- Ankle swelling
- Rapid/irregular pulse
- Breast Tenderness
- Chest pain
- High blood pressure
- Low blood pressure
- Other _____

Head, Eye, Ear, Nose & Throat

- Facial pain
- Headache
- Head injury
- Neck pain or stiffness
- Frequent sore throat
- Blurred vision
- Double vision
- Overly sensitive to light
- See spots or shadows
- Hearing loss in both ears
- Ear ringing
- Disturbance in smell
- Runny nose
- Dry mouth
- Sore tongue
- Other _____

Gastrointestinal and Hepatic

- Trouble swallowing
- Nausea or vomiting (throwing up)
- Abdominal (stomach/belly) pain
- Anal itching
- Painful bowel movements
- Infrequent bowel movements
- Liquid bowel movements
- Loss of bowel control
- Frequent belching or gas
- Vomiting blood
- Rectal bleeding (red or black blood)
- Jaundice (yellowing of skin)
- Other _____

Musculoskeletal

- Back pain or stiffness
- Bone pain
- Joint pain or stiffness
- Leg pain
- Muscle cramps or pain
- Other _____

Skin, Hair

- Dry hair or skin
- Itchy skin or scalp
- Easy bruising
- Hair loss
- Increased perspiration
- Sun sensitivity
- Other _____

Genitourinary

- Itchy privates or genitals
- Painful urination
- Excessive urination
- Difficulty in starting urine
- Accidental wetting of self
- Pus or blood in urine
- Decreased sexual desire
- Other _____

Females

- No Menses
- Menstrual irregularity
- Painful or heavy periods
- Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- Painful menstrual periods
- Painful intercourse or sex
- Sterility infertility
- Abnormal vaginal discharge
- Other _____

Males

- Impotence (weak male erection)
- Inability to ejaculate or orgasm
- Scrotal pain
- Abnormal penis charge
- Other _____

Explanation
