FOLLOW UP VISIT

(Adult or older high-functioning child)

Patient Name_____Date of birth_____

Describe what “good things” are happening since last visit:

Please list how anything we recently added affected you.

What are your current concerns:

Please describe any health changes since our last visit.

Did you see any other doctors/providers since I saw you last? If so, please list who and outcome of visit.

Any obvious problems with allergies (nasal congestion, snoring, restless sleep, rashes)? Please describe. Are your symptoms controlled?

How is your memory, thinking, ability to focus, ability to think through complex ideas or tasks?

Any repetitive thinking?

Any obsessive behaviors or actions you feel compelled to do?

How is your mood over all?

Do you have mood swings?

Any difficulty calming down when you are upset?

Do you ever feel like hurting yourself or others?

How is your physical energy and endurance?

If you get hot, do you sweat appropriately?

Describe your sleep patterns. For example, any trouble falling asleep?
Staying asleep?
Are you restless?
Has anyone commented that you stop breathing during the night?
Do you have cramps or restless legs at night?
Do you wake feeling fully rested?
Any late afternoon fatigue or hyperactivity (restlessness)?

Please describe your stools:

- How often do you go?
- Any trouble with loose or watery stools?
- Any abdominal pain? If so, when?
- Any difficulty having a bowel movement?

Any problems urinating? If so, describe:

Describe your diet:

Gluten free? Casein free? SCD? GAPS? How long?

List protein sources:

List Carbohydrate sources:

List Fruits and Vegetables commonly eaten:

What do you usually drink? How much each day?

Do you feel poorly when you eat certain foods?

Please list all medications and supplements and their doses (unless unchanged and in our record): Do you swallow pills? Y N

Current Detox therapy: Sauna—Y N Epsom salt bath---Y N
Detox foot bath—Y N

Any other specific questions you have for this visit?