



# TODAY'S VISIT

**Complete this form and take to the health care practitioner**

Location of today's visit \_\_\_\_\_ Name of health care practitioner \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Purpose of visit \_\_\_\_\_

## Checklist of items to bring with you on appointment:

- This form completed
- Updated medication list
- Monitoring forms/charts (i.e. sleep, behavior, NTG-EDSD Tool/Screen, etc.)
- Summary of your medical history and medical records (For 1st time appointments and/or if needed)
- Health insurance card (if needed)
- Residential forms (CBRF, AFH, etc.)
- Something fun to do (if you have to wait i.e. book, puzzle, games, etc.)
- Other items requested by health care practitioner

Hello, My name is \_\_\_\_\_ I like to be called \_\_\_\_\_

I have an appointment with \_\_\_\_\_ today.

I am a new patient: Yes  No  Phone \_\_\_\_\_ Address \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male  Female

The person with me is: \_\_\_\_\_ and is my \_\_\_\_\_ (caregiver, family member, etc.)

He/She's contact info: \_\_\_\_\_ My pharmacy is: \_\_\_\_\_

I have these allergies: \_\_\_\_\_

<input type="checkbox"/> I am here because this is a follow-up appointment You treated me for _____ I did <input type="checkbox"/> did not <input type="checkbox"/> take the medicine I didn't take it because _____ I did <input type="checkbox"/> did not <input type="checkbox"/> do what you told me I didn't do it because _____ _____	<input type="checkbox"/> I am here because I am having problems I'm having problems with _____ I have pain ____ I feel sick ____ (See back of form) It started and/or I noticed it _____ It occurs (how often) _____ I have treated myself at home by _____ _____
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Possible causes/contributing factors could be: \_\_\_\_\_

I had changes in my living or social environment: Yes  No  (family illness/loss, move, etc.)

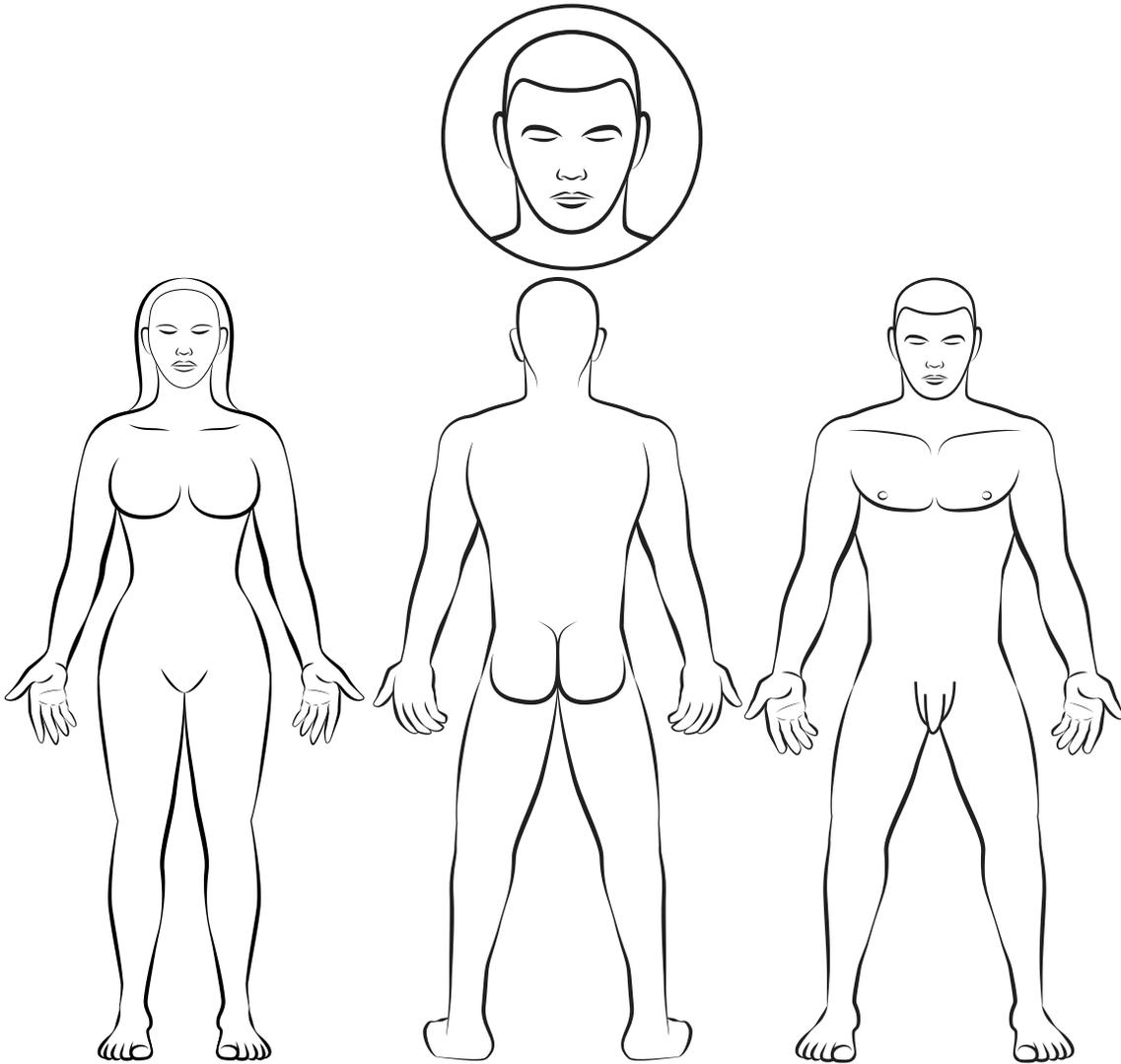
I had some recent medication changes: Yes  No

I had some recent physical changes (may also refer to the NTG-EDSD form): Yes  No

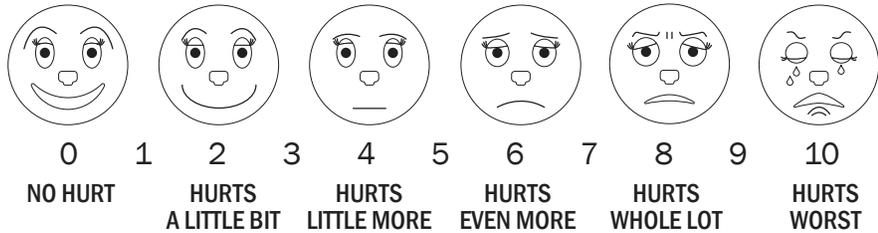
Activity level  Mobility  Bladder  Bowel  Weight  Swallowing  Eating patterns  Sleeping

Other \_\_\_\_\_

**Location of symptoms:  
USE THE FOLLOWING PICTURES OF THE BODY TO HELP  
YOU SAY WHERE YOU HURT OR FEEL SICK.**



**Severity of symptoms  
(circle one)**



It's worse when: \_\_\_\_\_ It's better when: \_\_\_\_\_

Conditions I am being treated for now: \_\_\_\_\_

Serious illnesses I have had in the past: \_\_\_\_\_

My sensitivities/triggers are: \_\_\_\_\_

**Health care practitioners I have seen since my last visit (doctor, dentist, care providers, etc.):**

Name \_\_\_\_\_ Location \_\_\_\_\_

Name \_\_\_\_\_ Location \_\_\_\_\_

Name \_\_\_\_\_ Location \_\_\_\_\_