Emory Treatment Method

Name: _____ **Date:** _____
Phone: _____**Pharmacy Phone:**_____

Patient's update or concern:

_____
_____
_____

Please Rate the following on a scale from 0 – 10
0 = lowest rating & 10 = highest; 7-9 is a normal range
***If you have missed a dose of your medication please inform us. Rate yourself WITHOUT including any extreme or unexpected life stressors. We are primarily interested in your sense of physical well-being. ***

Appetite ___	Focus ___	Vital Signs:
Calm ___	Libido ___	Blood Pressure _____
Energy ___	Mood ___	Pulse _____
Sleep ___		Weight _____

How long does it take for you to achieve sleep?
0 – 15 min ___ 15 – 30 min ___ 30 – 60 min ___
Other _____
Once you achieve sleep, do you have difficulty staying asleep? Yes ___ No ____
If so how many times do you wake? _____
Are you known to snore? Yes__ No__ Who reports your snoring: _____
To what extent do you snore: _____
Are you having any pain?
Yes ___ No ___
If yes, please describe and **Rate on a scale from 0 – 10**.
_____
Are you craving any substances?
Yes ___ No ___
If yes, please describe and **Rate on a scale from 0 – 10.**
_____
Are your thoughts faster, slower or the same rate as your speech? _____
How frequent is your bowel elimination? _____

List **CURRENT** medications (Please include medications prescribed by another physician, over-the-counter medications, nasal spray and vitamins/supplements.)
*** Please specify GENERIC or BRAND for all medications***

Name of medication *(i.e., Omega 3-6-9)*	Strength *(i.e., 1000 mg)*	Daily Dosage *(i.e., 2 caps/day)*	Rate effectiveness ***-1**=adverse, **0**=none, **+1**=slight, **+2**=modest, **+3**=marked*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			