Acupuncture and Oriental Medicine Questioner

Provider: Mark Gutkin LAc, MS., Diplomat in OM (NCCAOM)
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This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you.
Please print this form and bring it with you for the initial visit. Thank you

PERSONAL INFORMATION

Name _____ Date _____

Home Address _____

City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____

Email _____ Family Physician _____

Occupation _____ Person Responsible for you account_____

Who should we thank for referring you to this office?_____

Sex: ☐ Female ☐ Male Height _____ Weight _____ Birth date _____ Age ___

Marital Status: ☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Widowed

Have you received acupuncture therapy before? ☐ Yes ☐ No If yes, when?_____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date		You	Your Relative	Approx. Date
Cancer	☐	☐	_____	Heart Disease	☐	☐	_____
Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
Hepatitis B/C	☐	☐	_____	Psychiatric Disorders	☐	☐	_____

Sexual Transmitted Diseases: ☐ Gonorrhoea ☐ Syphilis ☐ AIDS ☐ HPV ☐ Chlamydia ☐ Herpes ☐ Date _____

Please indicate if any of the following pertain to you:

☐ Low Blood Pressure ☐ Pregnancy ☐ Strep Infection

☐ Faint ☐ Latex Allergy ☐ Lymph nodes removed

☐ Seizures ☐ Other Allergies: To What? ☐ Alcoholism

☐ Pacemaker ☐ Asthma ☐ Birth Trauma

☐ Blood -Thinning Meds ☐ MS ☐ Lyme disease

Other Major Illnesses, Injuries, Surgeries, Cosmetic Work:

Please provide details: _____

When? (Dates) _____

List any medications and supplements you are currently taking: (Continue on the back if necessary)

Medicine	Dosage	Reason	Length	Prescribed by	Date of last Check-up

DIET (GIVE A TYPICAL DAY'S INTAKE)

Breakfast	Lunch	Dinner	Snacks
Sun **Mon** **Wed**			

Food cravings: _____

Food intolerance: _____

How much do you consume (servings per day/week)

Meat _____ Sugar/Sweets _____ Dairy/Cheese/Milk _____

Are you always thirsty? ☐ Yes ☐ No Do you prefer ☐ Hot or ☐ Cold drinks?

Taste Preference: ☐ Salty ☐ Sour ☐ Bitter ☐ Sweet ☐ Spicy

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/Black Tea	☐	☐		Tobacco	☐	☐		Water Intake	☐	☐	
No-medical drugs	☐	☐		Alcohol	☐	☐		Soda pop	☐	☐	

Is Nutrition or Diet something you'd like to improve or be evaluated for? □ Yes □ No
Are you open to Herbal remedies as a part of your care? □ Yes □ No

Are you active? (check one) □ Sedentary Job w/o exercise □ Sedentary Job w/ Much Exercise
□Sedentary Job w/ Some Exercise □ Active Job w/o Extra Exercise □ Active Job w/ Exercise

What type of exercise do you do? _____

Would you like evaluation for the best form of exercise for your body and health? □ Yes □ No

How would you characterize your life in terms of stress? (check one)

□ High Stress □ Much Stress □ Fairly Stressed □ Mild Stress □ Periodic Stress □ Not Stressed

Would you like to be handling stress better, or reduce the effects of stress? □ Yes □ No

Do you experience any of the following moods often? (check all that apply)

□ Depression □ Anxiety □ Insecurity □ Anger □ Irritability □ Phobias □ Nervousness

□ Mood Swings □ Sadness □ Short Tempered □ Obsessive Thinking □ Isolated □ Hopelessness

Would you like to be evaluated for possible treatment solutions for these states? □ Yes □ No

What are the main health problems for which you are seeking treatment? (in the order of priority)

1. _____ 3. _____
2. _____ 4. _____

What other forms of treatment have you sought?

1. _____ 2. _____ 3. _____ Results? _____

Date of the Last Physical evaluation _____ Date of the recent Blood Work _____

SYMPTOM SURVEY (DURING PAST 3 MONTHS)

General
☐ Recurrent Infections
☐ Night Sweats
☐ Sweat easily
☐ Bleed or bruise easily
☐ Thirst with no desire to drink
☐ Fatigue
☐ Sudden energy drops
Time of day_____
☐ Poor Sleep
☐ Tremors
☐ Poor Balance
☐ Edema

Skin
☐ Rashes
☐ Itching
☐ Eczema
☐ Oozing
☐ Pimples
☐ Dry skin / scalp
☐ Recent moles

Cardiovascular
☐ Chest discomfort/pain
☐ Heart Palpitations
☐ Cold hands or feet
☐ Swelling of hands or feet
☐ Blood Clots
☐ Spider veins
☐ Fainting
Other _____

Respiratory
☐ Difficulty breathing
☐ Pain with breathing
☐ Shallow breathing
☐ Shortness of breath
☐ Production of phlegm
color _____
☐ Recurrent cough
☐ Bronchitis
☐ Pneumonia
☐ Asthma/Wheezing
Other _____

Digestion
☐ Bad breath
☐ Change in appetite
☐ Nausea
☐ Vomiting
☐ Heartburn
☐ Indigestion
☐ Belching
☐ Abdominal pain or cramps
☐ Weight gain
☐ Weight loss
☐ Loose stools / Diarrhea
☐ Strong smelling stools
☐ Bloody stools
☐ Pale stools
☐ Green stools
☐ Black stools
☐ Constipation
(not daily, or difficult)
☐ Pain with passing stools
☐ Gas
☐ Rectal pain
☐ Hemorrhoids
☐ Anorexia nervosa
☐ Bulimia
Other _____

Head/Eyes/Ears/Nose/Throat
☐ Headache
Where _____
When _____
☐ Migraines
☐ Dizziness
☐ Discharge from ear
☐ Poor hearing
☐ Ringing in ears
☐ Blurry vision
☐ Night blindness
☐ Color blindness
☐ Spots in front of eyes
☐ Eye pain
☐ Excessive tearing
☐ Glasses
☐ Sore eyes
☐ Facial pain
☐ Nose bleeds
☐ Nasal discharge
☐ Blocked nose
☐ Snoring
☐ Grinding teeth
☐ Teeth problems
☐ Recurrent sore throat
☐ Hoarseness
☐ Tonsillitis
☐ Swollen glands
☐ Sores on lips/mouth
Other _____

Genito-Urinary
☐ Pain on urination
☐ Urgency with urination
☐ Frequent urination
☐ Blood in urine
☐ Decrease in urinary flow
☐ Unable to hold urine
☐ Incontinence at night
☐ Dribbling urination
☐ Kidney stones
☐ Prostate problems
☐ Impotency
☐ Changes in sexual drive
☐ Rashes
☐ Do you wake at night to urinate?
How many times? _____
Other _____

Musculoskeletal
☐ Neck ache/pain
☐ Back ache/pain
☐ Knee ache/pain
☐ Shoulder pain
☐ Elbow/Forearm pain
☐ Hand/Wrist pain
☐ Foot/Ankle pain
☐ Joint/Bone problems
☐ Torn tissues
☐ Prostheses
☐ Muscle pain/weakness
☐ Hernia
Other _____

Neurological
☐ Seizures
☐ Nerve damage
☐ Paralysis
☐ Stroke
☐ Sleep disorder
☐ Concussion
☐ Vertigo
☐ Lack of coordination
☐ Loss of balance
☐ Poor memory
☐ Difficulty in concentrating
Other _____

Behavioural
☐ Vacant
☐ Moody
☐ Easily susceptible to stress
☐ Aggressive/Bad temper
☐ Lose control of emotions
☐ Anxiety
☐ Panic Attacks
☐ Depression
☐ Fear

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing:

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	_____
Diet	☐	☐	☐	☐	☐	_____
Self	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	_____
Exercise	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	_____

FOR WOMEN

of pregnancies____ # births ____ # premature births ____ # miscarriages ____ # abortions ____
Age of 1st menses____ # days between menses ____ Duration of menses ____
Age of menopause ____ Date of last PAP ____

☐ Painful periods ☐ Irregular periods ☐ Light periods ☐ Heavy periods

Color of flow:	**Amount of flow:**	**# of pads you use per day:**	**Pain/cramping:**
☐ pale/light red	☐ spotting	1st day ___	☐ No
☐ red	☐ light	2ND day ___	☐ Yes
☐ bright red	☐ even throughout	3RD day ___	□ before flow □ mild
☐ dark red	☐ heavy	4th day ___	□ during flow □ moderate
☐ dark red/brown	☐ clots	+days ___	□ after flow □ severe

Other symptoms related to menses:

☐ Discharge	☐ Headache	☐ Nausea	☐ Constipation	☐ Diarrhea
☐ Swollen Breasts	☐ Mood Swings	☐ Increased Appetite	☐ Decreased Appetite	☐ Insomnia

Other:

☐ Fibroids	☐ Postcoital bleeding	☐ Infertility	☐ Vaginal discharge
☐ Vaginal sores	☐ Nipple discharge	Other _____	

Do you practice birth control? ☐ yes ☐ no What type and for how long? _____

FOR MEN

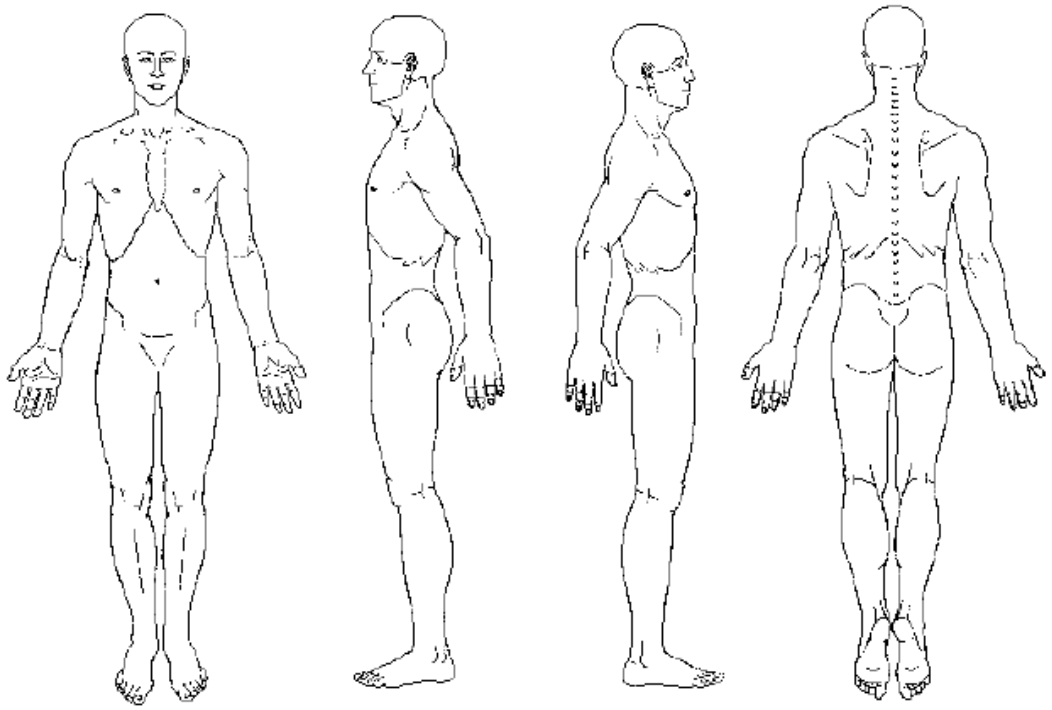
Date of last prostate check up _____ PSA results _____
Manual prostate exam results _____
Lab results
_____

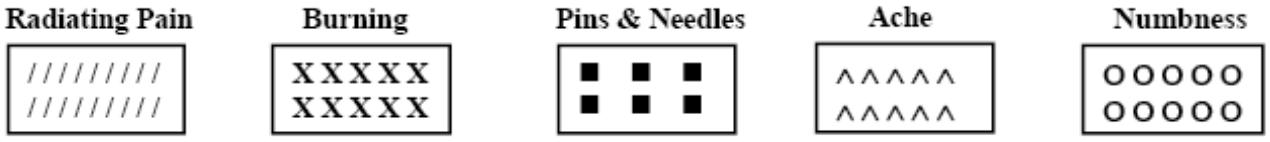
Frequency of Urination: daytime _____ nighttime _____
Color of urine: ☐ clear ☐ murky ☐ odor: _____

Symptoms related to prostate

☐ Prostate problems	☐ Delayed stream	☐ Dribbling	☐ Incontinence	☐ Retention of urine
☐ Rectal dysfunction	☐ Increase libido	☐ Decreased libido	☐ Premature ejaculation	☐ Impotence
☐ Back pain	☐ Groin pain	☐ Testicular pain	Other _____	

Pain chart - please mark painful or areas of distress on the chart below (use words if necessary)





Date the pain began: _____ Cause: _____

What makes pain **better:** ☐ pressure, ☐ heat, ☐ cold, ☐ exercise, ☐ rest, ☐ bath, etc. _____

What makes pain **worst:** ☐ pressure, ☐ heat, ☐ cold, ☐ exercise, ☐ rest, ☐ bath, etc. _____

Diagnostic Tests (List date/findings):

X-Ray_____

MRI_____

CAT_____

Surgeries (date/type)/Additional notes:

_____

_____

_____

_____

INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT

I request and consent to the performance of acupuncture and other Chinese medicine procedures. I understand that my signature on this form indicates that I have read the following, and understand that if I have any questions about the treatment, I should ask the practitioner.

1. Nature of Treatment: The treatment modalities may include acupuncture, massage therapy, moxa, acupressure, cupping, gua-sha, electric acupuncture, Chinese herbs and nutritional evaluation. I understand that the modalities will be explained to me prior to treatment for my condition.
2. Purpose of Treatment: I understand that the purpose of the treatment is to resolve my condition. The procedures used will attempt to remedy bodily dysfunction or diseases, to modify or prevent the perception of pain, and to regulate the body's physiological functions.
3. Risks of Treatment: I understand that Chinese medicine procedures have been shown to be safe and effective. However, I understand that there are some uncommon risks. These may include:
    - Mild discomfort during or after the insertion of a needle, dizziness, fainting, localized bruising or swelling, gastro-intestinal upset with the use of Chinese herbs, temporary aggravation of symptoms that existed prior to treatment;
    - Some herbs and acupuncture points are contra-indicated during pregnancy. Please notify your practitioner if you are or might be pregnant.
4. Use of Disposable Needles: I understand that to prevent any possibility of infection from acupuncture, all needles used are sterile, disposable. Needles are never reused.
5. Unforeseen risks: I understand that the practitioner can not anticipate or explain all risks and complications which may occur during or after treatment. I understand that they will exercise judgment based upon their determination in my best interests. I understand that I may stop treatment at any time.

Patient advisory to consult a physician: To comply with Article 160, section 8211.1 (b) of NYS Education law, we must advise that you consult a physician regarding your condition.

OFFICE POLICIES & PROCEDURES:

Insurance Policies: This office is an out-of-network provider with most insurance plans. I agree to pay for treatment sessions in the event that my health insurance policy does not cover those services. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Payment by check or cash is expected at the time of service. Fees are $170 for the initial visit and $120 for a follow-up.

Your scheduled appointment is our first priority. If you need to reschedule, please notify the office at least 1 business day (24 hours) in advance to avoid a service charge. A missed appointment or cancellation with less then 24 hours notice will be charged at full rate.

Please allow *approximately* an hour and a half for your first appointment and an hour for subsequent visits. An effective, thorough acupuncture treatment is *not* dependent on time. All treatments are tailored to patient needs, and as we become familiar with your health patterns, less time is sometimes needed for consult.

Wear something comfortable and loose fitting. If it has been more than 4 hours since your last meal, eat a small snack prior to your treatment. (This is important to prevent dizziness or fainting!)

The success of your treatments is dependent on a couple things:

- The healing partnership between you and your healthcare provider.

You always have a choice in whether or not to follow the suggestions given to you. Understand that some of the suggestions (diet, exercises, stretching, herbs, supplements, etc.) are crucial to facilitate the healing process.

- Consistency.

Exercising once does not allow for cardiovascular strength and weight loss, nor do inconsistent and infrequent workouts. If you are inconsistent in treatment recommendations, it will take longer to reach your goals.

Congratulations on your commitment to your health!
We look forward to serving you! If you have any questions, please ask!

I have read and agree to the above. _____ Signature _____ Date

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Following is a whole body review of systems. Please check the box next to any symptoms that you regularly experience, or that you have experienced in the last two weeks.

Some symptoms are listed more than once. Please be sure to check the box each time.

LUNGS

Lung Qi Deficiency
- ❑ Easy sweat (even at rest)
- ❑ A lot of sweat
- ❑ Low voice
- ❑ Feeling like you don't want to speak
- ❑ Shortness of breath, even at rest
- ❑ Cough
- ❑ Watery nasal discharge
- ❑ Frequent colds

Lung Yin Deficiency
- ❑ Dry cough
- ❑ Cough with very little, sticky mucous (may have a streak of blood in it)
- ❑ Dry mouth and/or throat

Phlegm-Heat in the Lungs
- ❑ Barking cough
- ❑ Yellow, green or dark brown phlegm
- ❑ Shortness of breath
- ❑ Asthma
- ❑ Tightness or pain in the chest

Wind cold/heat
- ❑ Fever
- ❑ Chills
- ❑ Sweating
- ❑ Stuffed or runny nose
- ❑ A lot of clear, watery phlegm in your nose
- ❑ Frontal headache (mostly on the forehead)
- ❑ Occipital headache (mostly in the back of the head)
- ❑ Temporal headache (on the sides/temples)
- ❑ Vertex headache (at the top of the head)
- ❑ Stiff neck
- ❑ Coughing up a lot of clear or white phlegm
- ❑ Coughing up a lot of yellow phlegm
- ❑ Scratchy or sore throat
- ❑ Thirst
- ❑ Swollen tonsils

SPLEEN

Spleen Qi Deficiency
- ❑ Loss of appetite
- ❑ Abdominal distention or bloating after eating
- ❑ Gas after eating
- ❑ Getting tired after eating
- ❑ Fatigue
- ❑ Weakness in your arms and/or legs
- ❑ Loose stool
- ❑ Edema

Spleen not controlling the blood
- ❑ Blotches on the skin
- ❑ Blood in the urine
- ❑ Blood in the stool
- ❑ Heavy menstrual bleeding
- ❑ Heavy uterine bleeding outside the menstrual period
- ❑ Easy bruising

Dampness (damp-heat or damp-cold)
- ❑ Chest oppression (like there is a belt on your chest pulled too tight)
- ❑ Epigastric oppression (same thing around the stomach area)
- ❑ Stomach ache that is relieved by heat
- ❑ White vaginal discharge
- ❑ Thirst without the desire to drink, or only drinking small sips
- ❑ Nausea
- ❑ Vomiting
- ❑ Loose stool with bad odor
- ❑ Burning sensation in the anus
- ❑ Burning urination
- ❑ Scanty urination
- ❑ Feeling like you have to urinate, but then very little comes out

Spleen Yang Deficiency
- ❑ "Bearing down" feeling in the abdomen
- ❑ Organ prolapse
- ❑ Hemorrhoids
- ❑ Hernia

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KIDNEYS

Kidney Yin Deficiency

- ❑ Dizziness
- ❑ Ringing in the ears
- ❑ Vertigo
- ❑ Deafness
- ❑ Chronic low-grade fever
- ❑ Afternoon fever
- ❑ Insomnia
- ❑ Malar flush (red cheeks)
- ❑ Mental restlessness
- ❑ Night sweating
- ❑ Feeling very hot at night
- ❑ Dry mouth at night
- ❑ Heat in the palms and soles
- ❑ Thirst
- ❑ Sore lower back
- ❑ Ache in the bones
- ❑ "Wet" dreams

Kidney Yang Deficiency

- ❑ Cold feeling in the low back and/or knees
- ❑ Feeling cold deep inside your body
- ❑ Weak legs and/or knees
- ❑ Trouble starting an erection
- ❑ Premature ejaculation
- ❑ Copious urination that is clear
- ❑ Apathy
- ❑ Lack of willpower
- ❑ Unwillingness to take on projects
- ❑ Female infertility
- ❑ Edema of the legs

Kidney Qi Deficiency

- ❑ Weak urine stream
- ❑ Dribbling after urination
- ❑ Urinary incontinence
- ❑ Waking up to urinate
- ❑ Feeling like you have to urinate but then nothing comes out
- ❑ Chronic vaginal discharge

Lung and Kidney Disharmony

- ❑ Shortness of breath on exertion
- ❑ Rapid and weak breathing
- ❑ Difficulty inhaling
- ❑ Asthma
- ❑ Cold sweats

Kidney and Liver yin Deficiency

- ❑ Dull headache in the back of the head/neck
- ❑ Insomnia
- ❑ Dream-disturbed sleep
- ❑ Numbness of the arms and/or legs
- ❑ Red cheeks
- ❑ Dizziness
- ❑ Dry eyes
- ❑ Blurred vision
- ❑ Tendency towards angry outbursts
- ❑ Ringing in the ears
- ❑ Nightsweat
- ❑ Dry stool
- ❑ Very little menstrual blood
- ❑ No menstrual blood
- ❑ Late periods

Kidney and Heart not communicating

- ❑ Heart palpitations, including flutters
- ❑ Mental restlessness
- ❑ Insomnia
- ❑ Poor memory
- ❑ Dizziness
- ❑ Ringing in the ears
- ❑ Deafness/feeling blocked in the ears

Kidney and Spleen yang Deficiency

- ❑ Weakness
- ❑ Mental fogginess
- ❑ Phlegm in the throat
- ❑ Breathlessness
- ❑ Feeling like you don't want to speak
- ❑ Abdominal distention
- ❑ Poor appetite
- ❑ Feeling cold (internally)
- ❑ Feeling cold (to the touch)
- ❑ Abundant urine that is clear
- ❑ Loose stool
- ❑ Diarrhea first thing in the morning
- ❑ Watery diarrhea
- ❑ Chronic diarrhea
- ❑ Edema of the abdomen and/or legs

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LIVER

Liver Qi Stagnation
- ❑ Tightness in the chest or above the stomach
- ❑ Frequent sighing
- ❑ Hiccups
- ❑ Depression
- ❑ Nausea and/or vomiting
- ❑ Poor appetite
- ❑ Sour regurgitation
- ❑ Acid reflux
- ❑ Belching
- ❑ Borborygmus
- ❑ Diarrhea
- ❑ Feeling wound up or restless
- ❑ Difficulty swallowing or a lump in the throat
- ❑ Irregular menstrual periods
- ❑ Painful menstrual periods
- ❑ PMS irritability

Liver Blood Stasis
- ❑ Nosebleeds
- ❑ Painful periods
- ❑ Irregular periods
- ❑ Dark menstrual blood
- ❑ Clots in the menstrual blood
- ❑ Abdominal pain
- ❑ Lump in the abdomen
- ❑ Purple nails, lips or skin

Liver fire
- ❑ Irritability
- ❑ Tendency towards angry outbursts
- ❑ Ringing in the ears
- ❑ Deafness
- ❑ Headache on the temples
- ❑ Dizziness
- ❑ Red eyes
- ❑ Thirst
- ❑ Bitter taste in the mouth
- ❑ Dream disturbed sleep
- ❑ Constipation
- ❑ Dark yellow urine

Damp-Heat in the Liver and Gallbladder
- ❑ Fever
- ❑ Urine is very dark and very little comes out
- ❑ Fullness and/or pain of the chest or above the stomach
- ❑ Jaundice
- ❑ Bitter taste in the mouth
- ❑ Nausea/vomiting
- ❑ Loss of appetite
- ❑ Abdominal distention or bloating
- ❑ Vaginal discharge
- ❑ Pain, redness and/or swelling of the scrotum
- ❑ Vaginal itching

Cold Stagnation in the Liver Channel
- ❑ Fullness or distention just over the bladder, especially with pain that radiates to the scrotum or vagina
- ❑ Straining of the testes
- ❑ Hernia
- ❑ Pain just over the bladder that feels better with warmth

Liver Blood Deficiency
- ❑ Dizziness
- ❑ Numbness of the limbs
- ❑ Insomnia
- ❑ Blurred vision
- ❑ Seeing spots in front of the eyes
- ❑ Very little or no menstrual blood
- ❑ Pale skin or lips
- ❑ Weakness of the muscles
- ❑ Muscle spasms or cramps (including in the feet and/or legs)
- ❑ Brittle nails
- ❑ Dry hair or skin

Liver Yang Rising
- ❑ Headache in temples or behind the eyes
- ❑ Dizziness
- ❑ Ringing in the ears
- ❑ Difficulty hearing
- ❑ Dry mouth and/or throat
- ❑ Insomnia
- ❑ Irritability
- ❑ Feeling worked up
- ❑ Shouting in anger

Liver Invading the Spleen
- ❑ Irritability
- ❑ Abdominal distention and/or pain
- ❑ Alternating diarrhea and constipation
- ❑ Dry stool
- ❑ Flatulence/gas

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HEART

Heart Qi Deficiency

- ❑ Heart palpitations or flutters
- ❑ Shortness of breath on exertion
- ❑ A lot of sweating (either at rest or during exercise)
- ❑ Fatigue
- ❑ Feeling "out of it"

Heart Yang Deficiency

- ❑ Feeling stuffiness or fullness around the heart
- ❑ Feeling cold
- ❑ Cold limbs (especially hands)

Heart Blood Deficiency

- ❑ Heart palpitations or flutters
- ❑ Dizziness
- ❑ Insomnia
- ❑ Dream disturbed sleep
- ❑ Difficulty remembering things
- ❑ Anxiety
- ❑ Feeling easily startled

Heart Yin Deficiency

- ❑ Uneasiness or feeling "fidgety"
- ❑ Red cheeks
- ❑ Chronic low grade fever
- ❑ Feeling hot in the afternoon
- ❑ Feeling "hot and bothered"
- ❑ Night sweating
- ❑ Dry mouth and/or throat
- ❑ Heat in the palms

Heart Fire

- ❑ Palpitations
- ❑ Thirst
- ❑ Sores on the mouth and/or tongue
- ❑ Feeling agitated
- ❑ Impulsiveness
- ❑ Insomnia
- ❑ Dark urine
- ❑ Blood in the urine
- ❑ Feeling like you have to urinate but then very little comes out
- ❑ Frequent urination of small amounts
- ❑ Pain on urination

Phlegm-Fire Misting the Heart

- ❑ Restlessness
- ❑ Heart palpitations
- ❑ Bitter taste in the mouth
- ❑ Insomnia
- ❑ Dream disturbed sleep
- ❑ Feeling easily startled
- ❑ Incoherent speech
- ❑ Mental confusion
- ❑ Rash behavior
- ❑ Tendency to hit or scold people
- ❑ Uncontrolled laughter or crying
- ❑ Agitation or shouting
- ❑ Muttering to yourself
- ❑ Mental depression

In this space, please feel free to write down any other signs or symptoms you want to mention that haven't been covered above:

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