New pt to clinic? ❑Yes ❑No **TSWF ENCOUNTER WORKSHEET with SF600 (v20110309)** **Date:** _____

Name: _____ **Contact Phone #:**_____ **Email:**_____

What is the main reason for **today's visit**?

How **long** have you had this issue?

Is this issue getting **better or worse**?

Please rate your **pain level** on a scale of 0 (no pain) to 10 (severe pain): # ___/10

Please complete information below:

If you have filled this form out before, please only list changes since last visit.

Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (list family members)	Current Medications
Do you have any of the following? (circle)		***HIGH BLOOD PRESSURE:***	**PLEASE INCLUDE DOSAGE. IF YOU HAVE A LIST WITH YOU HAVE IT READY.**
High Blood pressure		***HIGH CHOLESTEROL:***	
High Cholesterol			
Diabetes		***DIABETES:***	
Asthma			
Heart Disease		***CANCER:***	
Obesity			
Cancer		***OTHER:***	
Had a Heart Attack			
Other:			

Please check if you take: ❑Vitamins ❑Over the counter meds ❑ Dietary Supplements ❑ Herbal meds ❑Weight loss meds

Please list any **allergies** you have (drug, food, latex) _____

❑Yes ❑No Do you consume any alcohol? If yes, Type? _____frequency? _____ amount?_____

❑Yes ❑No Do you now or have you ever used **tobacco** products? (If YES, check the box that applies to you)

❑ I CURRENTLY USE TOBACCO PRODUCTS What type of tobacco? _____ How much per day? _____

❑ I QUIT USING TOBACCO PRODUCTS When did you quit?_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	[0]	[1]	[2]	[3]
Little interest or pleasure in doing things	❑ Not at all	❑ Several days	❑ More than half the days	❑ Nearly every day
Feeling down, depressed, or hopeless	❑ Not at all	❑ several days	❑ More than half the days	❑ Nearly every day

Female Questions: ❑Yes ❑No Could you be pregnant? Date of Last Period _____

Date Last Pap? _____ ❑Normal? ❑Abnormal? ❑Postmenopausal? Menopause at Age_____

❑Yes ❑No Hysterectomy? Type of Birth Control Used_____

Would you say your general health is? ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

❑Yes ❑No Do you have any learning disabilities? _____

What is your preferred language? _____

What is your preferred method for learning: ❑ Verbal ❑ Written ❑Visual ❑ Other: _____

❑Yes ❑No Do you feel safe at home?

❑Yes ❑No Do you have an advanced directive?

❑Yes ❑No Do you have any cultural or religious beliefs that may affect your care?

❑Yes ❑No Are you enrolled in EFMP?

Are there other concerns you would like addressed today? _____

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