OUTCOME PROGRESS REPORT

Changes in Address or Insurance: Yes ☐ No ☐ ; if yes, please see an office staff member.
Please see office staff member to add your preferred pharmacy.

Patient's Name: ____________________________________DOB________________________

Current Medications: ____

Adverse Event Evaluation (please circle)

Appetite:	Good	Fair	Poor	Notes: __________________	
Sleep:	Good	Fair	Poor	Notes: __________________	
Attention:	Good	Fair	Poor	Notes: __________________	
Anxiety:	None	Low	High	Notes: __________________	
Mood:	Pleasant	Depressed	Anxious	Oppositional	Other: ____________
Taking Medication Regularly:		Yes	No		
Duration Effect of Medication (s):		12 hr	10 hr	8 hrs	6 hrs or less

Other Concerns: ____

____

Review of Symptoms

Please circle the appropriate symptom:

ALLERGY:
Allergy Symptoms

CONSTITUTIONAL:
Fever, Fatigue,
Chills, Chronic Pain

CVS:
Chest Pain, Palpitation
Swelling of ankles

ENDOCRINOLOGY:
Temperature Intolerance
Hot Flashes, Excessive Thirst
Urinating Frequently

EYES:
Blurry Vision, Eye Pain
Visual Disturbance

GI:
Heartburn, Abdominal Pain
Vomiting, Nausea
Diarrhea, Blood in Stool
Rectal Bleeding

GENITOURINARY:
Painful urination, Blood in urine
Frequent Urination
Frequent urination at Night

HEENT:
Swollen Glands, Throat Pain
Ear Pain, Nasal Congestion

MUSCULOSKELETAL:
Neck Pain, Neck Stiffness
Joint Aches, Back Pain
Muscle aches

NEUROLOGY:
Headache, Dizziness
Lightheaded, Numbness
Tremors

RESPIRATORY:
Cough, Shortness of breath
Wheezing, Painful respiration

SKIN:
Rash, Acne

Office Use Only: ☐ Scanned **Please fill out front and back ➡**

DEPRESSION TRACKING FORM

For each item, chose how well it describes how you felt over the ***past two weeks,*** including today.

Rating Guidelines 0= not at all (0 days per week) 1=rarely true (1 days per week) 2=sometimes true (2 days per week) 3=often true (3 days per week) 4=almost always true (every day)	**With Medications**				
1. I felt sad or depressed	0	1	2	3	4
2. I was not as interested in my usual activities	0	1	2	3	4
3. My appetite was poor and I didn't feel like eating	0	1	2	3	4
4. My appetite was much greater than usual	0	1	2	3	4
5. I had difficulty sleeping	0	1	2	3	4
6. I was sleeping too much	0	1	2	3	4
7. I felt very fidgety, making difficult to sit still	0	1	2	3	4
8. I felt physically slowed down, like my body was stuck in mud	0	1	2	3	4
9. My energy level was low	0	1	2	3	4
10. I felt guilty	0	1	2	3	4
11. I thought I was a failure	0	1	2	3	4
12. I had problems concentrating	0	1	2	3	4
13. I had more difficulties making decisions than usual	0	1	2	3	4
14. I wished I was dead	0	1	2	3	4
15. I thought about killing myself	0	1	2	3	4
16. I thought that the future looked hopeless	0	1	2	3	4

Overall, how much have symptoms of depression interfered with or caused difficulties in your life during the past two week?

0 not at all 1 a little bit 2 a moderate amount

3 quite a bit 4 extremely

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