The highest priority of Your Best Life is to help you create health.

To facilitate this process, please take your time and fill out this questionnaire as accurately as possible.

INTAKE & HEALTH QUESTIONAIRE

8010 S. 101st E. Avenue, Suite 200
Tulsa, OK 74133

Phone: (918) 893-1440
Fax: (918) 893-1481

Patient Information

Patient: Last Name	First (Legal)	Middle	Nickname:	Maiden/Previous Name:

Address:	City:

Email Address:	State:	ZIP:

Home Phone:	Cell Phone:	Date of Birth:	Age:	Social Security Number:

Race: ☐ White ☐ American Indian ☐ Black ☐ ________________	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐Separated	Primary Language: ☐ English ☐ ______________________

Employer:	Occupation:	Length of Employment:

Employer Address:	Work Phone:

Spouse's Name: Last Name	First	DOB:	Social Security Number:

Spouse's Employer:	Work Phone:

Referring Person/physician:	Primary Care Physician:	PCP Phone:

Next of Kin / Emergency Contact outside of Home

Last Name	First	Middle Int.	Relationship:	Phone Number:

Address:	City:	State:	ZIP:	Social Security Number:

Employer:	Occupation:

Employer Address:	Work Phone:

I understand I am responsible for all payment for all charges related to services I receive by Your Best Life, LLC. during my care.

I understand Your Best Life, LLC. requires payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. If my account is not paid within 90 days of the date of service and no other financial arrangements have been made, I will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting my account.

I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand it is my responsibility to alert Your Best Life, LLC. of any changes in my medical status.

***The undersigned agrees to observe and abide by all of the above statements*.**

Patient Signature: ____ Date: ________________________

Witness: ____

IMPORTANT PATIENT INFORMATION

Appointments

- **Initial on line ______ Consultation fee: Initial hour $400; after this $250 per hour of time spent, broken into 15 minute increments.**
- There is a 24-hour cancellation policy for all appointments. If you do not cancel your appointment prior to the 24-hours you will be charged $200, before you are allowed to reschedule.
- As a courtesy, we call to confirm the appointment prior to your scheduled time; ultimately it is your responsibility to keep the scheduled appointment or reschedule.
- Follow up consultations in person or over the phone to review lab results or treatment programs: $125/half hour.
- For any forms or letters required to be filled out by the physician you will be charged $50/form.

Lab Test

- After your initial and follow up consultations, lab tests and/or diagnostic test may be ordered.
- We will attempt to order these test at facilities that will bill your insurance, however, some of these test are very specialized and require specific labs/facilities. You will be responsible to pay any fees incurred.
- Some lab test are performed "fasting", which means nothing except water for 10 hours before your visit.
- Some lab test take up to 6 weeks to be finalized. The results will be mailed or emailed to you when they are finalized. If your follow up was not scheduled at the time of your last visit, then you should contact the office to schedule.
- Interpretation of results require a scheduled appointment, either in person or over the phone, with your physician. This allows for questions to be answered directly and helps to avoid miscommunication by passing information through YBL staff.

Billing / Insurance

- Payment for appointments, phone consultations and all other services provided by YBL is expected at time of service. We accept cash, check or credit cards. All credit card payments will be processed the same day as the service is rendered.
- If test kits are sent to you, you will be billed the day the kit is mailed.
- We do not accept insurance and we cannot assist you with claim resolution. We will provide you with a billing summary, which you can submit to your insurance carrier.

Primary Care Physician

- **Initial here ______**Please note – Dr. Bischoff is not your primary care physician. We recommend you have a primary care physician at home.

I have read understand the above information.

______________________________________ ____________________

Patient Signature ***Date***

Patient Pledge / *Consent for Treatment*

Your health and healing depend on our commitment to doing the best we can and your commitment to:

- ***Primary Care Physician (PCP)***
  You will need a PCP while working with Your Best Life. We cannot see you here without a PCP on record. Your Best Life does not handle medical or mental health emergencies. Your PCP will only be contacted by YBL clinical staff if a situation arises that requires the attention of your local provider.
  Please note – Dr. Bischoff is not and will not be your primary care physician.
- ***A Partnership and a Process***
  Some chronic illnesses can take weeks, months or even longer to improve. If you do not see immediate results, do not give up. At YBL, healing is based on a partnership and a process. It takes time, patience and persistence to find and treat the root causes of your illness. You will have to work hard, and so will we.
- ***Prescribed Changes***
  Your commitment to comply with prescribed dietary changes, supplements, and medications, as well as other treatment recommendations, is the key to healing. If you do not follow the plan with reasonable consistency, your progress will likely be stalled.
- ***Patient / Physician Commitment***
  Establishing and maintaining a good working relationship with your physician here at YBL, is a key element in your success. Once treatment is initiated with your physician, it is important that you remain in that physician's care and stay in regular communication with our clinical team.
- ***Ongoing Support***
  Functional medicine is a different approach from the existing health care model. Chronic illness can contribute to challenges with focus, cognition, energy and mood. Some of the changes we ask of you may feel overwhelming at times. We urge every patient to find support at home. Family and friends may provide support, but that is not always adequate. It is the obligation of the YBL team to identify difficulty you might be having with behaviors that are interfering with your stated goals and to recommend additional outside services. These services may include a range of behavioral and mental health therapies. Refusal to make appropriate use of recommended treatment may result in termination of YBL services.

_____(initial) **I have read and agree to the statements above.**

_____(initial) **I understand that the nutrition modality used by Your Best Life utilizes nutrient protocols for treatment**.

By signing this form, I agree to participate in this modality with the understanding that even with the highest level of compliance, desired outcomes are not guaranteed and that levels of response may vary.

Signed by: ____ ______________________________
Signature of Patient or Legal Guardian Date

____ ______________________________
Print Patient's Name Patient's Date of Birth

____ ______________________________
Print Legal Guardian's Name, if applicable Relationship to Patient

Notice of Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice Describes Our Practices and Those Of:

Any health care professional allowed to enter information into your chart;
Any volunteer we allow to help you while you are here; and
All employees of any hospital, clinic, laboratory, or other facility affiliated with Your Best Life, LLC.
All of these people follow the terms of this notice. They may also share protected health information with each other for treatment, payment or health care operations as described in this notice.

Our Pledge Regarding Health Information:

We understand that health information about you and your health is personal. Your health information is contained in a medical record that is the physical property of Your Best Life, LLC. We are committed to protecting health information about you. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

Your Best Life, LLC. Is Required By Law To:

Make sure that medical information that identifies you is kept private;
Give you this notice of our legal duties and privacy practices with respect to medical information about you;
Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations;
Follow the terms of the notice that is currently in effect.

How Your Best Life, LLC. May Use and Disclose Your Health Information:

For Treatment: Your Best Life, LLC. may use and disclose your health information to provide you with medical treatment or services. *For example, a health care provider, such as a physician, nurse or other person providing health services to you, will record information in your record that is related to your treatment.* This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment: Your Best Life, LLC. may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. *For example, a bill may be sent to you or a third-party payor, such as an insurance company, HMO or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. Or, unpaid service balances may be referred to a collection agency to obtain payment.*

For Health Care Operations: Your Best Life, LLC. may use and disclose your health information for operational purposes. *For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:*

* Evaluate the performance of our staff;
* Assess the quality of care and outcomes in your case and similar cases;
* Learn how to improve our facilities and services; and
* Determine how to continually improve the quality and effectiveness of the health care we provide.

Clergy: Unless you inform us that we should not do so, your religious affiliation may be related to a member of the clergy even if they do not ask for you by name.

Appointments/Health-Related Products and Services: Your Best Life, LLC. may use your information to contact you to provide appointment reminders. Your Best Life, LLC. may also contact you to tell you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved In Your Care: Your Best Life, LLC. may release relevant health information to a family member, friend, or anyone else you designate in order for that person to be involved in your care or payment related to your care. Your Best Life, LLC. may also disclose health information to those assisting in disaster relief efforts so that others can be notified about your condition, status and location.

Fundraising: Your Best Life, LLC. does not use your information for fundraising.

Required By Law: Your Best Life, LLC. may use and disclose information about you as required by law. For example, Your Best Life, LLC. may disclose information to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities (e.g., state health department, Center for Disease Control, etc.) to prevent or control disease, injury, or disability, or for other public health activities.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.

Health Oversight Activities: Your Best Life, LLC. may disclose your health information to a health oversight agency for activities authorized by law. Examples of these activities include audits, investigations, and inspections to monitor the health care system and compliance with laws or regulations.

Decedents: Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation: Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research: Your Best Life, LLC. may use your health information for research purposes after a receipt of authorization from you or when an institutional, review board (IRB) or privacy board has waived the authorization requirement by its review of the research proposal and has established protocols to ensure the privacy of your health information. Your Best Life, LLC. may also review your health information to assist in the preparation of a research study.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Your health information may be disclosed for specialized government functions such as protection of public officials or reports to various branches of the armed services.

Workers' Compensation: Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other Uses And Disclosures: Other uses and disclosures will be made only with your written authorization. You may revoke an authorization except to the extent Your Best Life, LLC. has taken action in reliance on it. State laws that offer a patient/plan member additional privacy protections may also apply.

Your Health Information Rights:

You have the right to:

Obtain a paper copy of this notice of information practices upon request;

and obtain a copy of your health information that is maintained by Your Best Life, LLC.;

Request an amendment to your health information under certain circumstances;

Request a confidential communication of your health information by alternative means or at alternative locations. Please be advised that this request for alternative means or locations of communications applies only to this provider or location;

Receive an accounting of certain disclosures made of your health information; and

Request a restriction on certain uses and disclosures of your information. Your Best Life, LLC. is not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid for your treatment out-of-pocket and in full.

Changes To This Notice:

Your Best Life, LLC. reserves the right to change the terms of this notice and make the new terms effective for all protected health information kept by Your Best Life, LLC. You may get a current copy by contacting our Your Best Life, LLC. Privacy Officer (address at the end of this notice). The effective date of the notice is in the top right-hand corner of each page.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with Your Best Life, Inc. or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Your Best Life, LLC., submit your written complaint to our Your Best Life, LLC. Privacy Officer (address at end of this notice). You will not be penalized for filing a complaint.

Contact Information For Questions Or To File A Complaint:

If you have any questions about this notice, want to exercise one of your rights that are described in this notice, or want to file a complaint, please contact the Your Best Life, LLC. Privacy Officer at:

Your Best Life, LLC. at: 8010 S 101st E Ave, Suite 200, Tulsa, OK 74133 918-893-1440

DATE: ____

PATIENT NAME: ____

DATE OF BIRTH: ____

SOCIAL SECURITY NO.: ____

In accordance with the provisions of Section 164.510(b) of the Health Insurance Portability and Accountability Act (HIPAA), I agree that Your Best Life, LLC. and its duly authorized agents and employees may disclose Protected Health Information directly relevant to involvement with my care, or payment related to my care, to my family members, other relatives, close personal friends and/or any other individuals that I indicate below who may contact Your Best Life, LLC. on my behalf.

NAME OF INDIVIDUAL(S) AND RELATIONSHIP: (Please print)
Indicate next to the name to identify the type of information to be disclosed

_____ Medical _____ Billing ___________________________________ Relationship: ____________________

_____ Medical _____ Billing ___________________________________ Relationship: ____________________

_____ Medical _____ Billing ___________________________________ Relationship: ____________________

I understand:

- At any time, I may add or remove individuals from this list by notifying Your Best Life, LLC. of my desire to do so. I understand that until I notify Your Best Life, LLC. of requested changes to this list, Your Best Life, LLC. may rely on this list and disclose information to the individuals listed above.
- Information disclosed to the individuals identified above may be subject to redisclosure by the recipient and no longer protected by federal law.

I understand that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

____ ____________________________
SIGNATURE OF PATIENT DATE

____ ____________________________
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure amount healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

8010 S 101st E Ave, Suite 200
Tulsa, OK 74135

ACKNOWLEDGEMENT OF RECEIPT OF
YOUR BEST LIFE, LLC. NOTICES

By signing this document, I acknowledge that I have received a copy of Your Best Life, LLC. Notice of Privacy Practices.

______________________	______________________	______________
Patient Name (Print)	Signature	Date

-OR-

______________________	______________________	______________
Patient Personal Representative (Print)	Signature	Date

Patient Social Security Number ____

Patient Birth Date ____________________

Your Best Life, LLC. Use Only________________________________

Date acknowledgement received: ______________________________

Signature of Your Best Life, LLC. employee: ________________________

-OR-

Reason acknowledgement was not obtained (declined to sign):

___

___

___

MEDICAL QUESTIONAIRE / HEALTH HISTORY

COMPLAINTS/CONCERNS:

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel worse?

What makes you feel better?

Current/Past Physicians

Specialty	Physician Name	City, State	Phone number	Fax Number
PCP				

ALLERGIES

Medicine/Supplement/Food	Since	Type of Reaction (Rash, Asthma, GI)

PHARMACY

Local Name	Address	Phone	Fax
Compounding	**Address**	**Phone**	**Fax**
Mail Order	**Address**	**Phone**	**Fax**

Patient Name: ____ **Date of Birth:** ____________________

Current Medications

Medication	Dose	Frequency	Start Date	Reason for use	Prescribed by

Previous Medications *(Last 10 years)*

Medication	Dose	Frequency	Start Date	Reason for Use	Prescribed by

Current Supplements

Medication	Dose	Frequency	Start Date	Reason for Use	Prescribed by

Have you ever experienced unusual side effects or problems from medications or supplements? **YES / NO**
Describe: ____
Have you had prolonged or regular use of NSAIDS? (Motrin, Aleve, etc.) **YES / NO** Type: ________________
Have you had prolonged or regular use of Tylenol? **YES / NO**
Use of Steroids in the past? (Prednisone, nasal allergy inhalers) **YES / NO** Last dose: ___________________
Frequent antibiotics? (Greater than 3 times/yr.) **YES / NO** Long term antibiotics? **YES / NO**
Have you had prolonged or regular use of Acid blocking drugs? (Prilosec, Zantac, Tums, etc.) **YES / NO**
Type: ________________________

Patient Name: ____ Date of Birth: ____________________

Past	Current	Disease/Diagnosis/Condition	Date of Onset		Past	Current	Disease/Diagnosis/Condition	Date of Onset
		GASTROINTESTINAL					**GENITAL & URINARY SYSTEMS**	
		Irritable Bowel Syndrome					Kidney Stones	
		Inflammatory Bowel Disease					Gout	
		Crohn's Disease					Interstitial Cystitis	
		Ulcerative Colitis					Frequent Urinary Tract Infections	
		Gastritis or Peptic Ulcer Disease					Frequent Yeast Infections	
		GERD (Reflux)					Erectile or Sexual Dysfunction	
		Celiac Disease					Other -	
		Other -						
							CANCER	
		CARDIOVASULAR					Lung	
		Heart Attack					Breast	
		Other Heart Disease					Colon	
		Stroke					Ovarian	
		Elevated Cholesterol					Prostate	
		Arrhythmia (irregular heart rate)					Skin	
		Hypertension (high blood pressure)					Other -	
		Rheumatic Fever						
		Mitral Valve Prolapse					**INFLAMMATORY / AUTOIMMUNE**	
		Other -					Chronic Fatigue Syndrome	
							Autoimmune Disease	
							Rheumatoid Arthritis	
		METABOLIC / ENDOCRINE					Lupus SLE	
		Type 1 Diabetes					Immune Deficiency Disease	
		Type 2 Diabetes					Herpes – Genital	
		Hypoglycemia					Severe Infectious Disease	
		Metabolic Syn. (insulin resistance)					Poor Immunity (Frequent Infections)	
		Hypothyroidism (low thyroid)					Food Allergies	
		Hyperthyroidism (overactive thyroid)					Environmental Allergies	
		Goiter					Latex Allergy	
		Endocrine Problems					Seasonal Allergies	
		Polycystic Ovarian Syndrome (PCOS)					Other -	
		Infertility						
		Weight Gain					**SKIN DISEASES**	
		Weight Loss					Eczema	
		Frequent Weight Fluctuations					Psoriasis	
		Bulimia					Acne	
		Anorexia					Melanoma	
		Binge Eating Disorder					Other -	
		Night Eating Syndrome						
		Eating Disorder						
		Other -					**NEUROLOGIC / MOOD**	
							Depression	
		MUSULOSKELETAL PAIN					Anxiety	
		Osteoarthritis					Bipolar Disorder	
		Fibromyalgia					Schizophrenia	
		Chronic Pain					Headaches	
		Other -					Migraines	
							ADD / ADHD	
		RESPIRATORY DISEASES					Autism	
		Asthma					Mild Cognitive Impairment	
		Chronic Sinusitis					Memory Problems	
		Bronchitis					Parkinson's Disease	
		Emphysema					Multiple Sclerosis	
		Pneumonia					ALS	
		Tuberculosis (TB)					Seizures	
		Sleep Apnea					Other -	
		Other -						

Patient Name: ____ Date of Birth: ___________________

Gynecological History *(for women only)*

Obstetric History *(Check box if yes and provide number of)*

□ Pregnancies_____ □ Caesarean_____ □ Vaginal Deliveries_____ □ Miscarriages_____ □ Abortion_____ □ Live Births_____

□ Post-Partum Depression □ Toxemia □ Gestational Diabetes □ Baby over 8 pounds □ Breast Feeding (____ months)

Women's Disorders/Hormonal Imbalances/Menstrual History

Age at first period: _______ Menses Frequency:__________ Length:___________ Last Menstrual Period: _________

Painful Periods: **YES / NO** Clotting: **YES / NO** Flow: **Heavy / Medium / Light** Skipped Periods: **YES / NO** For how Long? _______

□ Use of Birth Control **Pills / Patch / Nuvaring / Depo Provera / Diaphragm / IUD / Condoms / Other** _________________________________

Are you in Menopause? **YES / NO** Age at Menopause: _____ □ Hysterectomy (Year ______)

□ Endometriosis □ Infertility □ Fibrocystic Breasts □ PMS

□ Fibroids □ Ovarian Cancer □ Breast Cancer □ Mood Swings

□ Joint Pains □ Vaginal Dryness □ Weight Gain □ Concentration/Memory issues

□ Hot Flashes □ Decreased Libido □ Weight Loss □ Loss of control of urine

□ Palpitations □ Painful Intercourse □ Headaches □ Use of Hormone Replacements

(Type ___________ How Long? __________)

Last Mammogram: ___________ Where: _________________________ □ Breast Biopsy (Date _________)

Last Pap:____________ □ Normal □ Abnormal Last DEXA Scan (Bone Density) ___________ Results: _________________

Men's History *(for men only)*

Have you had a PSA test? **YES / NO** PSA Level: □ **0 - 2** □ **2 - 4** □ **4 - 10** □ **> 10**

□ Change in Libido □ Prostate Enlargement □ Prostate Infection

□ Impotence □ Difficulty Obtaining an Erection □ Difficulty Maintaining an Erection

□ Weight Gain □ Loss of Control of Urine □ Urgency/Hesitation/Change in Urine Stream

□ Weight Loss □ Concentration/Memory issues □ Nocturia (urination at night) How many times? _____

Patient Birth History

□ Term □ Premature Complications during Birth? ____

Complications during Pregnancy? ____

□Breast Fed How Long? ___________ □ Bottle Fed Issues: ____

Age of introduction of: Solid Foods: ____________ Dairy: _____________ Wheat: _____________

Did you eat a lot of candy or sugar as a child? **YES / NO**

Dental History

□ Silver Mercury Fillings How Many? ______ □Gold Fillings

□ Root Canals □ Implants □ Dentures □ Tooth pain

□ Bleeding Gums □ Gingivitis □ Problems Chewing □ Grind Teeth

Do you brush regularly? **YES / NO** Floss regularly? **YES / NO**

Patient Name: ____ Date of Birth: ___________________

X	PREVENTATIVE TEST	DATE OF TEST		X	SURGERIES	DATE
	Full Physical Exam				Appendectomy	
	Bone Density (DEXA)				Hysterectomy +/- Ovaries	
	Colonoscopy				Gallbladder	
	Cardiac Stress Test				Hernia	
	EBT Heart Scan				Tonsillectomy	
	EKG				Dental Surgery	
	Occult Blood Test – Stool test for Blood				Joint Replacement ______________________	
	Upper GI Series				Heart Bypass	
	Upper Endoscopy				Heart Valve Replacement	
	MRI -				Angioplasty or Stent	
					Pacemaker	
	CT Scan -				Other -	
	Ultrasound -					
	Other -				None	

HOSPITALIZATIONS (Nonsurgical):

Date -	Reason -	Hospital -

Additional Information you feel may be important -

Patient Name: ____ Date of Birth: _____________________

FAMILY HISTORY *(Please check all that apply)*	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at Death (if deceased)												
Cancer												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease (Such as Lupus)												
Irritable Bowel Disease												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Disease												
Genetic Disorders												
Substance Abuse (Such as Drug or Alcohol Abuse)												
Psychiatric Disorders												
Depression												
Schizophrenia												
Attention Deficit Disorder												
Autism												
Bipolar Disease												

Patient Name: ____ Date of Birth: ____________________