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AGENDA, INTERVAL HISTORY & COUNSELING

NAME:

DATE: f_agenda_2021_04_07.docx

DIRECTIONS: 1) Download to your desktop, 2) Complete form, 3) Save changes to your desktop, 4) attach to email to staff@cohlife.org

Food, Drink, and Activities last 24 hours:

SINCE YOUR LAST VISIT, have you had any...	No	Yes	Describe
A1 ...change in your health ins. coverage, address, employer?			
A2 ...visits to <input type="checkbox"/> other practitioners, <input type="checkbox"/> hospitals, <input type="checkbox"/> ER's, (explain)?			
A3 ... <input type="checkbox"/> medications started, changed or stopped (check and explain)?			
A4 ...visits to therapies <input type="checkbox"/> psych, <input type="checkbox"/> PT, <input type="checkbox"/> chiro, <input type="checkbox"/> acu, <input type="checkbox"/> other?			
A5 ...change in your family's medical status?			
A6 ...change in your stress (relationships, money, health, etc)?			
A7 ...change in your work status?			
A8 ...change in your exercise program?(freq, type)			
A9 ...change in your diet/ fluids/ smoking/ drinking?			
A10 ...change in weight or overall health?			
A11 ...any new allergies to meds or latex?			
A12 ...rashes or other skin changes?			
A13 ...bruising or bleeding?			
A14 ...change in bowels or stomach?			
A15 ...change in sleep quality?			
A16 ...change in ability to walk, twist, climb stairs, drive, do buttons/laces			
A17 ...new joint/muscle pains/stiffness or swelling of joints/extremities?			
A18 ...changes in mood, memory, concentration, coordination, energy?			
A19 ...changes in numbness or weakness?			

B1 Time/contents of breakfast :	B2 Time/contents of lunch :
B3 Time/contents of dinner :	B4 Snacks past 24 hrs
B5 Snacks after dinner (7pm):	B6 Fluids past 24 hrs
B7 # of BM's in last 48 hours:	B8 Exercise past 48 hrs
B9 Activities 2 hrs before bed:	B10 Time to bed last night:
B11 Hours in bed last night:	B12 # of sleep interruptions :
B13 BP & Blood Sugar w time:	B14 Weight w time and clothes:
B15 Current niacin times/dose:	B16 Current iodine (time/dose):
B17 Current Vit C (times/dose)	B18 Med/Supps added/stopped:

Additional Notes:

Your name and date are required (above). IF this SEND button does not work on your desktop, save this document to your desktop and then attach to an email. Send email to: staff@cohlife.org

Please leave blank:

CHECK OFF YOUR PRIORITIES for today's visit:	No	Yes	Describe
C1 REVIEW: prior visit, actions, responses, this agenda			
C2 GOALS/PROBLEMS: update status, make changes or new issues			
C3 LABS to ORDER or REVIEW: please send data from other sources in advance			
C4 PRESCRIPTION REFILLS: requests must come from the patient, NOT the pharmacy			
C5 SUPPLEMENTS review: Please send grid edits with this agenda PRIOR to visit.			
C6 PROTOCOL review: such as food plan, challenges, detox, test doses			
C7 OTHER:			