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AGENDA, INTERVAL HISTORY & COUNSELING

NAME:

DATE:

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Reset Form

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

	SINCE YOUR LAST VISIT, have you had any...	No	Yes	Describe
A1	**...change in your health ins. coverage, address, employer?**	☒	☐	
A2	...**visits** to ☐ other practitioners, ☐ hospitals, ☐ ER's, (explain)?	☒	☐	
A3	... ☐ **medications** started, changed or stopped (check and explain)?	☒	☐	
A4	...visits to **therapies** ☐psych, ☐PT, ☐chiro, ☐acu, ☐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?	☒	☐	

	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:**	☐	☐	

Food, Drink, and Activities last 24 hours:

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:

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Please leave blank: