North Springs Psychiatry & TMS Center

7660 Goddard St, Suite 130 • Colorado Springs, CO 80920
Phone: (719) 639-2486 • Fax: (719) 375-1039 • www.northspringspsychiatry.com

About Our Forms

Our forms are fillable for your convenience! Please submit the forms using one of the options below.

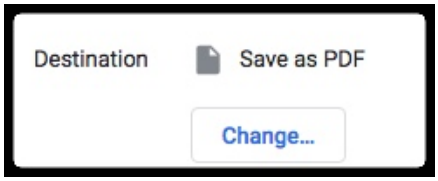
To submit the completed forms:

Option 1: On your computer

a. Complete the forms by clicking into each field and filling in the information

b. Email completed, unsigned forms to Admin@NorthSpringsPsychiatry.com . We will have them printed and ready to sign at your appointment.

   i. Click "Print" 

   ii. Change printer to "Save as PDF" and save to your desktop. Attach to email. 

c. Or, print out the completed forms and bring them to your appointment.

Option 2: Print and complete by hand

a. Print the forms

b. Fill out the information by hand

c. Sign forms and bring to your appointment

If you have any questions please reach out to our office.

We look forward to seeing you soon!

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Patient Questionnaire
REVIEW OF SYSTEMS QUESTIONNAIRE

Patient Name:_____

What do you most want to discuss today? (Select all that apply)

GENERAL

Fatigue	___ Yes
Decreased appetite	___ Yes
Fevers	___ Yes
Weight loss	___ Yes
Weight gain	___ Yes
Insomnia	___ Yes
Do you have a living will	___ Yes
Do you smoke	___ Yes
Do you drink alcohol	___ Yes
Are you in pain	___ out of 10

EYES, EARS, NOSE & THROAT

Visual changes	___ Yes
Hearing loss	___ Yes
Sore throat	___ Yes
Nasal congestion	___ Yes
Runny nose	___ Yes
Ear pain	___ Yes

NECK

Swollen glands	___ Yes

RESPIRATORY

Shortness of breath	___ Yes
Cough	___ Yes
Wheezing	___ Yes

CARDIOVASCULAR

Chest pain	___ Yes
Palpitations	___ Yes
High blood pressure	___ Yes
Stroke	___ Yes

DIABETES

A1C results	___ Yes
Blood sugars	___ Yes
CGM - Senor problems	___ Yes
CGM - Sensor readings	___ Yes
Digestion problems	___ Yes
Labs	___ Yes
Lipids	___ Yes
Loss of consciousness	___ Yes
Medications	___ Yes
Meter problems	___ Yes
Meter readings	___ Yes
Pump problems	___ Yes
Pump settings	___ Yes
Sores on feet	___ Yes
Tingling/numbness-feet	___ Yes

SKIN

Rashes	___ Yes
Itching	___ Yes
Mole changes	___ Yes

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GASTROINTESTINAL

Abdominal pain	☐ Yes
Constipation	☐ Yes
Bloody stool	☐ Yes
Diarrhea	☐ Yes
Heartburn	☐ Yes
Nausea/Vomiting	☐ Yes

GENITOURINARY

Change in bowel habits	☐ Yes
Painful urination	☐ Yes
Bloody urine	☐ Yes
Increased urination	☐ Yes
Leaking urine	☐ Yes
Erectile Dysfunction	☐ Yes

GYNECOLOGIC

Irregular menses	☐ Yes
Abn. vaginal discharge	☐ Yes
Pelvic pain	☐ Yes
Pain with intercourse	☐ Yes
Painful menses	☐ Yes
Pregnant	☐ Yes

MUSCULOSKELETAL

Joint pain	☐ Yes
Muscle pain	☐ Yes
Leg swelling	☐ Yes

NUROLOGIC

Headaches	☐ Yes
Dizziness	☐ Yes
Difficulty walking	☐ Yes
Numbness or tingling	☐ Yes

PSYCHIATRIC

Anxiety	☐ Yes
Irritability	☐ Yes
Sexual problems	☐ Yes
Suicidal ideation	☐ Yes
Depression	☐ Yes
Concerns about your emotional or physical safety	☐ Yes

Additional information or concerns: