Weekly Treatment Check-in

Please answer the following questions as truthful as possible

Patient Name: ___________________________________ Date:____________________________

Have you had any medication changes in the last 1-2 weeks? **Yes** **No**

If yes, please explain what medication/dose changed and when:

____

____

Have there been any changes to your sleep patterns? **Yes** **No**

If yes, how has your sleeping pattern changed?

____

____

Have you seen your PCP since your last appointment? **Yes** **No**

Have you had any lab work done since you last appointment? **Yes** **No**

If yes, what was tested and what were the results?

____

____

Have you noticed any improvements since starting treatment? **Yes** **No**

Please explain:

____

____

____

Have you experiencing any side effects since starting treatment? **Yes** **No**

Please explain:

____

____

____

Have there been any changes regarding your health? **Yes** **No**

If yes, please explain:

____

____

Do you have any specific concerns for the doctor? **Yes** **No**

If yes, please explain

____

____

____

____

____

____

____

____