



Dear Patient,

Thank you for taking the time to fill out the following new patient forms before your first visit. **Please mail, fax or drop off your new patient paperwork to the office prior to your initial appointment.** This will allow our time together to be more efficient and productive.

Please bring the following with you to your initial appointment:

- A copy of any blood (lab) work that has been done in the past year, as well as any reports from any relevant past imaging studies (x-rays, MRI, CT scans, etc). It is not necessary for you to bring copies of your films to your initial visit. Your doctor's office may fax this information directly to us. Fax: 947-0926.
- If you take multiple nutritional supplements, please bring your bottles with you to your appointment.
- Your insurance card, or a copy of the front and back of your insurance card.
- Credit card, check, or cash for your insurance copayment, coinsurance or deductible.

DR. HOUSE PATIENTS ONLY: If your needs include weight loss, please follow the following instructions to prepare for Bioimpedance Analysis (BIA Test) the day of your first appointment. If your appointment is for any other reason, please you may disregard the following.

How To Prepare for the BIA Test (Body Composition Test)

Please adhere to the following guidelines prior to your appointment:

- a. Do not eat a heavy meal at least 4 hours prior to testing. (You may have a **light** snack)
- b. Do not exercise for 12 hours prior to testing.
- c. Do not consume alcohol for 24 hours prior to testing.
- d. Drink at least 1 quart of water (32 oz.) one hour before your test (you may void as needed).
- e. Do not drink caffeine the day of your test.
- f. Insure access to your feet with removable footwear (no pantyhose).

Please be punctual so as to benefit fully from your appointment. There will be a \$100 no-show fee assessed if cancellation is not made at least 24 hours prior to your appointment.

Our office will bill your insurance. However, please be advised the services we provide may not be covered. If this is the case, discounted rates and other payment arrangements are available. For billing and other questions, you may contact Jessica Whitney, practice manager, at jwhitney@drpeine.com.

Please feel free to contact us if you have any questions or concerns.

Sincerely,

Chris Peine, DO drpeine@drpeine.com
Angela House, DO drhouse@drpeine.com



NEW PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Gender: M / F SSN: _____ Marital Status: Married Single Divorced Widowed Separated

Date of Birth: _____ Age: _____

Race (please circle): American Indian or Alaska Native Asian Black or African American

Native Hawaiian or other Pacific Island Hispanic Caucasian Other Decline to Answer

Ethnic Group (please specify, for example: Argentinean, Chilean, etc):

Primary Language (please circle): Arabic Chinese English French German Japanese Russian Spanish

Vietnamese Other

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Responsible Party Name (if patient is a minor): _____

Relationship to Patient: _____ Contact Number: _____

Emergency Contact Name: _____ Phone: _____

Do you have an Advanced Medical Directive and / or Living Will and Durable Power of Attorney? ___ Yes ___ No

Preferred Message / Contact Phone: Phone Mail Secure Email Patient Portal

Preferred Reminder Method: Cell Phone Home Phone Mail Email Patient Portal

Email Address: _____

I was referred to Dr. Peine/Dr. House by: _____

Primary Care Physician name and contact information: _____

Names of any specialists you are seeing, please provide phone and fax numbers if available: _____



INSURANCE INFORMATION

NOTE: Our office policy is that we do not bill for motor vehicle related accidents. We will be happy to see you as a self-pay patient until settlement is made between you and the insurance company. We will gladly refund you what you have paid out of pocket once we receive payment from your insurance company.

Is this visit related to an injury of any kind? Yes No If yes, what is the initial date of injury? _____

Is this a work comp related injury? Yes No If yes, insurance claim No: _____

Name of Work Comp Carrier and Billing Information : _____

Is this a motor vehicle accident related injury? Yes No

Primary Insurance Co: _____

Policy Holder: _____ Relationship to Patient: _____ Date of Birth: _____

Secondary Insurance Co: _____

Policy Holder: _____ Relationship to Patient: _____ Date of Birth: _____

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I hereby consent to such treatment/procedures as may be rendered by Dr. House or Dr. Peine. I authorize the release of any information necessary to process my claim and the direct payment of benefits to Peine Osteopathic Medicine. I understand that I may be charged for late appointments. I assume all financial responsibility for the balance of charges not included in the insurance coverage. I understand that neither Dr. House nor Dr. Peine is my primary care physician and that I will contact my primary care physician or dial 911 in the event of an emergency.

Patient Signature _____
(parent if patient is a minor)

Printed Name: _____ Date: _____



Patient Portal Authorization Form

Patient Name: _____

Responsible Party Name: _____

Personal Email Address: _____

(Please supply the personal email address of the person who will be using the patient portal)

Purpose of this Form:

The patient portal offers patients of Peine Osteopathic Medicine a secure way to view parts of their records and communicate with our staff. Secure messaging is a valuable communication tool for our practice, but it has certain limitations and guidelines. Please read this form thoroughly before signing.

How the Patient Portal Works:

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site. Once you are logged into the portal you will have access to only your records or those for whom you are legally responsible.

Via the Patient Portal you will be able to:

- ❖ Use the message function to communicate with our staff
- ❖ Schedule, confirm, cancel or reschedule an appointment
- ❖ Communicate about billing questions
- ❖ Request a referral or medication refill
- ❖ View health summary information in your electronic chart and send staff requests to update information
- ❖ View demographic / insurance information and send staff requests to update information
- ❖ Print or save an electronic copy of the health summary using the continuity of care record (CCR) format.

How to Participate in the Patient Portal:

Once this form is agreed to and signed, you will receive a user name and password via your personal email account. There is a link to the patient portal on our website, www.peineosteopathic.com. You will be able to log in using the username and password provided.

Protecting Your Private Health Information and Risks:

This method of communicating and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two important factors, we need you to make sure we have your correct email address and you MUST inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address as this information might be available to your employer. You need to keep unauthorized persons from learning your password. If you think someone has learned your password, you should promptly change it via the patient portal.

Conditions of Participating in the Patient Portal:

We understand the importance of privacy with regard to your health care and will continue to protect the privacy of your medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices. Access to this secure web portal is an optional service and we may suspend or terminate it at any time for any reason. If we do, we will notify you as promptly as possible. As a user of the patient portal and by signing this form you agree to:

- 1) Not transmit any electronic information that violates the rights or privacy of any party.
- 2) Use the web portal in any way that would violate local, state or federal laws.
- 3) Not transmit materials that are obscene, defamatory, abusive, slanderous or otherwise likely to result in harm to others.
- 4) Intentionally distribute viruses code or take any other action that could compromise the security of our computer system.

Patient / Guardian Acknowledgement:

Signature: _____ Date: _____



INFORMED CONSENT REGARDING NUTRITIONAL SUPPLEMENT AND FUNCTIONAL MEDICINE LABORATORY TESTING

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term **drug** is defined as an “article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.” Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient’s diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

You are under no obligation to purchase nutritional supplements at our clinic.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Your medical physician may or may not agree with the necessity for—or our interpretation of—these tests. If you have any questions or concerns, please discuss them with our doctors.

I have read and understand the above:

Signature

Date



PROVIDER NOTICE OF PRIVACY PRACTICES

In accordance with federal law, 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.

Uses and Disclosures: We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods. We may use or disclose identifiable health information about you with your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area.

Patient Rights: You can also request a copy of our notice at any time. For more information about our privacy practices, contact Peine Osteopathic Medicine PLLC. **Complaints:** If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Peine Osteopathic Medicine, PLLC. You may also send a written complaint to the U.S. Department of Health and Human Services.

I Acknowledge I have read and understand the above Notice of Privacy Practices:

Patient Signature: _____
(parent if patient is a minor)

Printed Name: _____ Date: _____



PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVES

I, _____, give my authorization to release my protected health information, including results of my laboratory tests, x-ray, CT, and / or other relative information to the following designated representative (s):

Patient Initials

Designated Representatives

_____ Spouse _____

_____ Children _____

_____ Other _____

_____ May be left on my answering machine at home

_____ May be left on my cell phone voice mail

_____ May not be given to anyone other than myself

Patient Signature: _____
(parent if patient is a minor)

Printed Name: _____ **Date:** _____

MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to these written questions. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will help us formulate a treatment plan.

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us?

When was the last time you felt healthy?

Did something trigger your change in health?

What makes you feel worse?

What makes you feel better?

Your current age: _____

ALLERGIES None

Please list any allergies to medications, supplements, or foods. Environmental allergies such as dust, pollen, etc. are unnecessary.

Medications/Supplement/Food	Reaction

PEINE

OSTEOPATHIC
MEDICINE

Reflux/Heartburn		
Celiac Disease		
Constipation		
Other		
Cardiovascular		
Heart Attack/Angina		
Heart Failure		
Stroke		
Arrhythmia/irregular heart beat		
High cholesterol/ triglycerides		
High Blood Pressure (hypertension)		
Rheumatic Fever		
Mitral valve prolapse		
Other		
Metabolic/Endocrine		
Diabetes I or II		
Low or high Thyroid		
Metabolic Syndrome (insulin resistance/ borderline diabetes)		
Low blood sugars		
Polycystic ovarian syndrome (PCOS)		
Infertility		
Weight Gain		
Weight Loss		
Eating disorder (Bulimia or Anorexia)		
Other		
Cancer (type)		
Genital/Urinary System		
Kidney Stones		
Urinary Infections (UTI)		
Yeast Infections		
Gout		
Interstitial Cystitis		
Sexual dysfunction/Erectile Dysfunction		
Other		
Musculoskeletal/Pain		
Osteoarthritis		
Chronic Pain		

PEINE

OSTEOPATHIC
MEDICINE

Other		
Inflammation/Autoimmune		
Fibromyalgia		
Rheumatoid Arthritis		
Chronic Fatigue Syndrome		
Lupus SLE		
Immune Deficiency Disease (HIV)		
Frequent Infections (describe)		
Environmental allergies		
Food Allergies		
Chemical Sensitivities		
Other		
Respiratory Diseases		
Asthma		
Chronic Obstructive Pulmonary Disease (COPD) or Emphysema		
Chronic Sinusitis		
Bronchitis		
Sleep Apnea		
Pneumonia		
Other		
Skin Diseases		
Eczema		
Psoriasis		
Acne		
Skin Cancer (type)		
Other		
Neurological/Mood		
Depression		
Anxiety		
Bipolar Disorder		
Schizophrenia		
ADD/ADHD		
Autism		
Headaches (Tension or Cluster)		
Migraine Headaches		

SURGERIES/MEDICAL PROCEDURES None

Date and Type of Surgery or Medical Procedure (i.e. Angioplasty with Stent -2006)

HOSPITALIZATIONS None

Date and Reason

FAMILY HISTORY

Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, offspring, aunt or uncle) with any of the following conditions:

Alcoholism _____	High cholesterol _____
Cancer, specify type _____	High blood pressure _____
Heart disease _____	Stroke _____
Depression/suicide _____	Bleeding or clotting disorder _____
Genetic disorders _____	Asthma/emphysema _____
Diabetes _____	Other _____

PSYCHOSOCIAL/STRESS/COPING

Do you drink alcohol? Yes No

If yes, how often do you drink alcohol? _____ # of drinks per week

Have you ever had a problem with alcohol? Yes No

If yes, please indicate time period (month/year): from _____ to _____

Have you ever used recreational drugs? Yes No

Have you ever used tobacco? Yes No

If yes, number of years as a nicotine user: _____ Amount per day: _____ Year quit: _____

What type of nicotine have you used? Cigarette Smokeless Cigar Pipe Patch/Gum

Do you feel worse at certain times of the year? Yes No

If yes, when? Spring Fall Summer Winter

Are you exposed to secondhand smoke regularly? Yes No

PEINE

OSTEOPATHIC MEDICINE

Do you have mercury amalgam fillings? Yes No

Do you have any artificial joints or implants? Yes No

Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes No

If yes, which one(s)? Lead Cadmium Arsenic Mercury Aluminum

Do odors affect you? Yes No

Do you feel significantly less vital than you did a year ago? Yes No

Are you happy? Yes No

Do you believe stress is presently reducing the quality of your life? Yes No

Do you feel you have an excessive amount of stress in your life? Yes No

Have you ever been abused, a victim of crime, or experienced a significant trauma? Yes No

Have you ever had psychotherapy or counseling? Yes No

Currently Previously If previously, from _____ to _____

Comments: _____

Occupation: _____

Marital Status: Single Married Divorced Gay/Lesbian Long Term Partnership Widow

List Children:

Child's Name	Age	Gender

Who is living in the household? _____

Hobbies and leisure activities: _____

EXERCISE

Do you exercise regularly? Yes No

If so, how many times a week? 1 time 2 times 3 times 4 or more times

When you exercise, how long is each session? Less than 15 min. 16–30 min. 31–45 min. More than 45 min.

What type of exercise is it?

Jogging/Walking Recreational Sports (type) _____

Strength Training Yoga/Pilates

Other _____

Rate your level of motivation for including exercise in your life. Low Medium High

List problems that limit activity _____

Do you feel unusually fatigued after exercise? Yes No

SLEEP/REST

Do you have trouble falling asleep? Yes No
 Average number of hours you sleep per night: >10 8-10 6-8 <6
 Do you wake up in the night? Yes No How many times? _____
 Do you feel rested upon awakening? Yes No
 Do you have problems with insomnia? Yes No
 Do you snore? Yes No
 Do you use sleep aids? Yes No

ANTIBIOTIC/ STEROID HISTORY

Have you taken frequent antibiotics? (> 3 times per year?) Yes No
 Long term antibiotics? Yes No If yes, how long? _____
 Have you taken oral steroids or other steroid medications? (e.g., cortisone, prednisone, nasal sprays, etc.)? Yes No If yes, length of treatment _____

DIET HISTORY

Are you on a special diet? Yes No If yes, describe _____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? Yes No
 If yes, please name the food or supplement and symptom(s) (Example: milk – gas and diarrhea):

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.?
 Yes No
 If yes, are these symptoms associated with any particular food or supplement(s)?

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet sodas	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels)	

PEINE

OSTEOPATHIC MEDICINE

Sodas with caffeine	
Sodas without caffeine	

Please give me an idea of your **usual** daily meals including snacks. **Please include time of day and approximate quantity:**

Breakfast: _____

Morning Snack: _____

Lunch: _____

Afternoon Snack: _____

Dinner: _____

Evening Snack: _____

Does skipping a meal greatly affect your symptoms? Yes No

Have you ever had a food that you craved or really "binged" on over a period of time?

Food craving may be an indicator that you may be allergic to that food. Yes No

If yes, what food(s)? _____

Do you have an aversion to certain foods? Yes No

If yes, what foods? _____

Do you feel as though your diet may be contributing to your problem(s): Yes No

If yes, please rate your level of motivation for changing your dietary habits.

Low Medium High

List problems that may limit dietary changes _____

INFANCY/CHILDHOOD HISTORY

QUESTION	YES	NO	DON'T KNOW	COMMENT
Were you a full-term baby?				
A preemie?				
Were you breast-fed?				
Bottle-fed?				

As a child, were there any foods that you had to avoid because they gave you symptoms?

Yes No If yes, explain _____

GASTROINTESTINAL HISTORY

Foreign Travel? Yes No Wilderness Camping? Yes No

PEINE

OSTEOPATHIC MEDICINE

Have you ever had severe diarrhea? Yes No

Do you see undigested food in your stool? (except for corn) Yes No

Do you feel bloated after meals? Yes No How long after you eat? _____

Please fill in the chart below with information about your bowel movements:

Frequency	√	Color	√
More than 1x/day		Medium brown consistently	
1x/day		Very dark or black	
4-6x/week		Greenish	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long, or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

Intestinal gas:

Daily

Occasionally

Excessive

Present with pain

Foul smelling

Little odor

PREVENTIVE AND DIAGNOSTIC TESTS (check box if yes and provide dates)

<input type="checkbox"/> Bone Density	
<input type="checkbox"/> Colonoscopy	
<input type="checkbox"/> Cardiac Stress Test	
<input type="checkbox"/> EKG	
<input type="checkbox"/> CT Scan	
<input type="checkbox"/> MRI	
<input type="checkbox"/> Ultrasound	
<input type="checkbox"/> Blood work/Labs	

(Office use only)

Form Reviewed in entirety by _____

Date: _____

MEDICAL SYMPTOMS

Name : _____

Date : _____

Please rate each of the following symptoms based upon your typical health profile since your last appointment using the point scale below:

Point Scale	0 - <i>Never or almost never</i> have the symptom
	1 - <i>Occasionally</i> have it, effect is not severe
	2 - <i>Occasionally</i> have it, effect is <i>severe</i>
	3 - <i>Frequently</i> have it, effect is not severe
	4 - <i>Frequently</i> have it, effect is <i>severe</i>

GENERAL

_____	Chills	
_____	Fatigue	
_____	Fever	
_____	Night sweats	
_____	Weight gain	
_____	Weight loss	Total _____

EYES

_____	Blurred vision (not near-or farsightedness)	
_____	Eye drainage	Total _____

EARS

_____	Ear pain	
_____	Ringing in ears	
_____	Hearing loss	
_____	Itchy ears	Total _____

NOSE

_____	Stuffy nose/nasal congestion	
_____	Runny nose	
_____	Seasonal Allergies	
_____	Excessive mucus formation	Total _____

MOUTH/THROAT

_____	Sore throat	
_____	Hoarseness	
_____	Swollen or discolored tongue, gums, or lips	
_____	Canker sores	Total _____

HEART

_____	Chest pain	
_____	Irregular or skipped heartbeat (palpitations)	
_____	Rapid or pounding heart (tachycardia)	
_____	Swelling of legs, ankles, or feet	Total _____

LUNGS

_____	Chronic cough	
_____	Shortness of breath	
_____	Difficulty breathing/wheezing	Total _____



Additional information required on back.

PEINE

OSTEOPATHIC MEDICINE

DIGESTIVE TRACT	_____	Nausea	
	_____	Vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching or passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	Total _____
GENITOURINARY	_____	Genital itching or discharge	
	_____	Frequent or urgent urination	Total _____
JOINTS/MUSCLE	_____	Joint pain	
	_____	Joint stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Back pain	
	_____	Neck pain	Total _____
SKIN	_____	Acne	
	_____	Dry skin	
	_____	Rashes	Total _____
NEUROLOGICAL	_____	Headaches	
	_____	Fainting	
	_____	Memory loss	
	_____	Vertigo	
	_____	Dizziness	
	_____	Numbness	
	_____	Weakness	Total _____
ENDOCRINE	_____	Hair loss	
	_____	Heat or cold intolerance	
	_____	Flushing or hot flashes	
	_____	Excessive sweating	Total _____
HEMATOLOGIC	_____	Easy bruising/excessive bleeding	
	_____	Swollen lymph nodes	Total _____
IMMUNOLOGY	_____	Frequent illness	Total _____
MIND	_____	Anxiety	
	_____	Depression	
	_____	Hyperactivity	
	_____	Loss of interest in pleasurable activities	
	_____	Feeling stressed	
	_____	Mood Swings	
	_____	Poor concentration	
	_____	Insomnia/sleep disturbance	
	_____	Irritability	Total _____
			GRAND TOTAL _____