Name:_____ Birthdate_____ Date_____

Please email (drklausnersoffice@gmail.com) or fax (831-420-1401) the information **4 days prior** to your appointment. Please keep all information to one page.

* On the attached medication list: include all prescriptions and over the counter medications you are presently taking with the dosage and frequency of each and also list all supplements you are presently taking with dosages and frequency.

* List your overall percentage of functioning since your last appointment _____
(0% = worst, 100% = best)

* Chief Complaint: since last appointment are you __ better, __ worse, __ the same?

* List your improvements in symptoms:

* List your worst or lingering symptoms (like fatigue, joint pain, muscle pain, sleep, brain fog, nerve pain/neuropathy, day/night sweats, chills, flushing, cough). For each one state if mild, moderate or severe.

* List any side effects of treatment like vaginal or oral yeast, intestinal gas, bloating.

* Any gastrointestinal symptoms: bowel movements __ soft, __ loose, __ bloody, __ watery with diarrhea, __ rectal itching. How many bm's per day ___ and describe.

* Any significant medical events since last appointment, like surgery, procedures, lab testing, other medical consults? If yes, what took place?

MEDICATIONS/SUPPLEMENTS LIST

Patient Name_____Date_____

Name	Dosage	Refill?