ENROLLMENT FORM

TODAY'S DATE: ________________

Demographic Information:

Last Name: ________________ First Name: ________________ MI: ____

Address: ________________________________

City: ________________ State: ____________ Zip: ____________

Home Phone: ________________ Cell Phone: ________________

E-mail: ________________________________

Primary Physician: ________________ Psychiatrist: ________________

Therapist/Counselor: ________________________________

DOB: ____________ Gender: ____________ Ht: ________ Wt. ________

Marital Status: ____________ Race: ____________

Pharmacy: ________________ Medication Insurance: ________________

May we leave a message at your phone number? Yes ☐ No ☐

Chief Complaint/Reason(s) for Visit:

- ☐ Medication Costs
- ☐ Too Many Medications
- ☐ Help Understanding your Medications
- ☐ Medication Problems / Side Effects
- ☐ Weight Gain
- ☐ Medications Aren't Working Well
- ☐ Other: ________________________________

History of Present Illness:

Please check all current medical conditions and indicate other current conditions not listed:

- ☐ Allergies
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina (Chest Pain)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Attention Deficit Disorder (ADD/ADHD)
- ☐ Bipolar Disorder
- ☐ Bladder Disorder
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic Kidney Disease
- ☐ Chronic Lung Disease
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Enlarged Prostate
- ☐ GERD/Stomach Ulcers
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Insomnia/Sleep Disorder
- ☐ Inflammatory Bowel Syndrome
- ☐ Nerve Pain
- ☐ Parkinson's Disease
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Psoriasis
- ☐ Pregnancy/Breast Feeding
- ☐ Restless Leg Syndrome (RLS)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Disorder

Other Medical Conditions Not Listed: ______________________________

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Past Medical History *(Please include Reason, Place, Dates and any other relevant information):*

Recent Surgeries: ______________________________

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Recent Hospitalizations: ______________________________

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Past Medical Conditions: ______________________________

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Family History:

- ☐ Heart attack in father or brother under age 55
- ☐ Heart attack in mother or sister under age 65
- ☐ Parent or sibling with alcoholism or drug abuse
- ☐ Parent or sibling with a mental illness

Other Relevant Family History: ______________________________

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Social History *(CIRCLE)*:

Tobacco:	None	0–1 pack/day	> 1 pack/day	
Caffeine:	None	< 2 cups/day	2–6 cups/day	> 6 cups/day
Alcohol:	None	< 2 drinks/week	2–6 drinks/week	> 6 drinks/week
Exercise:	< 1 hr/wk	1-2.5 hrs/wk	2.5-5 hrs/wk	> 5 hrs/wk
Dairy Products (milk, yogurt, cheese, fortified orange juice):	None	1–2 servings/day	3–4 servings/day	> 4 servings/day
Medical Marijuana:	NO		YES	

Pharmacist Notes: ______________________________

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Medications:

Name of current medication and strength	How often do you take it?	How long have you been on it?	What are you taking it for?	Doctor who prescribes it?	Is the medication working for you?

Over-the-Counter, Vitamins, and Other Medications (please include on the medication list on page 4):

- ☐ Multivitamins
- ☐ Vitamin D
- ☐ Other vitamins
- ☐ Calcium supplements
- ☐ Herbal medicine or nutritional supplements
- ☐ Nutritional energy drinks (Ensure, Boost)
- ☐ Grapefruit juice
- ☐ Birth control (for women of childbearing age)
- ☐ Something for headaches or aches and pains
- ☐ Cough syrup, cold medicine, nasal spray
- ☐ Allergy medicines
- ☐ Eye Drops
- ☐ Inhalers
- ☐ Something for upset stomach, heartburn, constipation, or diarrhea
- ☐ Something for anxiety or trouble sleeping
- ☐ Medicated creams or lotions
- ☐ Sample medications from the doctor
- ☐ Medication from a family member or friend
- ☐ Medication from the Internet

Immunization History: *Please indicate to the best of your knowledge*

Influenza Vaccine (Flu Shot)	Yearly: ☐ Yes ☐ No
Pneumoccal Vaccine	Once after age 65 or every 5 years if received before age 65: ☐ Yes (age)______ ☐ No
Zoster Vaccine (Shingles)	Once after age 60 or if indicated: ☐ Yes (age)______ ☐ No

Medications History:

Medication Allergies (please list medication and type of reaction): ______________________________

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Medications taken in the past (include results or problems with each): ______________________________

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Approximate Medication Costs:

Monthly Prescription Costs to You: ______________________________

Monthly Non-prescriptions Medication Costs: ______________________________

Medication Review Requests:

Is there a specific participating pharmacist you would like to request? ______________________

Please list any concerns you would like to have addressed by the consulting pharmacist:

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FOR OFFICE USE ONLY

Last labs: ______________________ Vital signs: ______________________

Medical Records Release signed: ________ Rating scales: ☐ PHQ Score ☐ MDQ Screen ________+/-

Handouts: ☐ NAMI ☐ MHC ☐ Warm Line

Lifestyle Recommendations: ☐ Exercise ☐ Smoking Cessation ☐ Sleep Hygiene
☐ Multivitamin ☐ Calcium supplement ☐ Assess for Adherence