

PLEASE NOTE: This form is not submitted online.

You must either:

1. Fill it out as presented online, print it, and bring it to your appointment, OR
2. Print it out, hand-write your information, and bring it to your appointment.

## **WELCOME**

Thank you for scheduling an initial appointment with our clinic. The purpose of this letter is to explain what you can expect from us during your first session. Please review this letter carefully.

The session usually lasts 45-60 minutes. The focus will be on determining the specific nature of your problem, and outlining an initial treatment plan. This is primarily an information-gathering meeting and will not involve much “talk therapy.” At the conclusion of this session, you will be given specific recommendations in order to begin your treatment.

We will be reserving this time specifically for you. If you are going to be late, please call our office. Also, please **call our office 48 hours prior to your appointment and confirm your attendance. If we do not hear from you, we will assume you have cancelled your appointment.** If it would make you feel more comfortable being accompanied by a friend or relative, please feel free to invite them.

Prior to your appointment, please review and complete the enclosed SELF-ASSESSMENT FORM. This will save time and allow for more discussion during the session. After completing the form, please bring the original with you to the session.

Insurance plans have become more numerous and complex. It is in your best interest to contact your insurance company prior to the initial session. We would recommend asking the following questions:

- 1) Are mental health services covered?
- 2) Is there a mental health deductible in addition to a medical deductible?
- 3) Is there a co-payment or other percentage that the patient is liable for?
- 4) Are our providers signed up with your plan?

As a service to you, our office will file your insurance claim. Co-payments and unmet deductibles will be due at the time of service. If you are unaware of your mental health benefits and we are unable to obtain the information from your insurance company, you will be asked to pay the entire fee at the time of service. Our office will reimburse you for the amount we collect from your insurance company.

**A 24-hour notice is required for all cancellations or you may be billed for the session.** If your insurance company requires treatment plans to be completed, this will be done in the follow-up visit with you. It is your responsibility to keep track of your authorized visits and bring the treatment plan to my office to be completed.

We hope this letter is helpful to you. If you have further questions, please feel free to contact our office. We look forward to our meeting. **Remember to confirm your attendance 48 hours prior to your appointment.**

Sincerely,

*~Dr. Ripperger and Associates, PLLC*

## **POLICY AND PROCEDURES**

**Please keep this for future reference.**

### **OFFICE HOURS:**

Office hours are Monday-Thursday from 9:00am to 5:00pm, excluding holidays. We are closed for lunch from 12:00pm-1:00pm. We are open some Fridays by appointment only. If you have an urgent problem requiring attention after-hours, you may contact the psychiatrist on call. This number changes on a monthly basis, so call our office at (405)579-4111 and the phone number for the on-call psychiatrist will always be updated on our voicemail. Prescription refills are NOT considered an emergency.

### **TELEPHONE CALLS:**

Our telephone is answered during regular office hours. You may leave a message on our voice mail after hours and your call will be returned the next business day. Calls received on weekends will be returned on Monday. After-hour telephone consultations with your physician will be reserved for emergency situations only. Providers answer phone messages by the end of the business day, after they are done seeing patients. Any voicemails left after 4:30 pm will be answered the next business day.

### **PRESCRIPTIONS AND REFILLS:**

Allow at least 3 days to process prescription renewals and/or pick-up requests. Sometimes requests are filled sooner than this. You are responsible for knowing when your medication will run out and accounting for the time it takes for our providers to authorize your request. Have your pharmacy fax a refill request to (405) 579-4223. Prescriptions require a scheduled follow-up appointment before we will refill. Count your pills and make sure you have enough to last until your next visit. No refills will be authorized if there is a history of missed appointments. No controlled prescriptions will be replaced if lost, stolen, misplaced, or overused. No prescriptions will be refilled on Fridays, Saturdays, Sundays or Holidays. Prescription phone-in/pick-up: Monday-Thursday, 9:00am-5:00pm. Prescriptions will not be filled for unauthorized walk-in patients. Signed "Controlled-Substance Policy" is required for narcotic/controlled medications. New symptoms require an appointment. Providers will not diagnose via phone. Medications are for the prescribed individual's use only. It is illegal to share or sell your medicine. You must pick-up your prescription in person, unless pre-authorized by our staff. Please note: we will not refill SUBOXONE® early under any circumstance.

A signed "Controlled-Substance Policy" is required for narcotic/controlled medications. Our practice takes the controlled substance policy very seriously. When the physician-patient relationship is strained due to perceived drug-seeking behavior, providers may continue service but cease in prescribing any controlled substances. In other cases, a patient may be terminated from this office and given direction to locate another medical office for continued care. Patient termination is at the discretion of the provider. Common reasons for termination include, but are not limited to, chronic noncompliance with recommended therapy, drug-seeking behavior, and abusive behavior towards staff, physicians, visitors or other patients.

### **Controlled Substance(s) Policy**

Due to recent guidelines by standard health maintenance agencies, we reserve the right to conduct an initial urine drug test and every sixty days thereafter for patients prescribed a controlled substance for sleep, anxiety, or any other condition.

## **TIPS FOR FUTURE VISITS**

**Please keep this for future reference.**

### **Once you are an established patient:**

1. Arrive 30 minutes early for your initial evaluation. Arrive 10 minutes early for all appointments thereafter to avoid last-minute rushes.
2. **To avoid being charged, give a 24 hour notice for cancellation.** Otherwise, your provider might charge you the full price of the visit. You will be responsible for the balance, and it must be paid off before services will be rendered again. Missed appointment charges are not covered by your insurance.
3. The physician on call is available 24 hours per day for emergencies. Do not use this service if it is not an emergency. Prescription refills will not be considered an urgent matter.
4. Count your pills before your visit. Get a written prescription to ensure you have enough medicine to last until your next visit.
5. Know your charge and write checks beforehand to make the best use of your session time.
6. Do not change appointment times unless absolutely unavoidable.
7. For routine matters, call during office hours only.
8. Know your insurance benefits. Call your insurance company before receiving services. Find out your exact copayment and/or deductible amount. Remember that if our provider is out-of-network, you will be responsible for the full charge.
9. Unless prior arrangements are made, payment is required at the time of service.
10. Please visit our website for additional information and services we provide: [www.normanpsychiatry.com](http://www.normanpsychiatry.com)

## PATIENT INFORMATION

Please provide the information requested in the spaces provided. This and all other information relating to your association with Joseph M. Ripperger, M.D. & Associates is regarded as strictly confidential and will not be share with anyone without your signed consent.

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: \_\_\_\_\_ Birth date: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Primary Insured or Responsible Party

If insurance does not pay your bill, who is financially responsible for the balance?

Name: \_\_\_\_\_ Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_

### INFORMATION

#1 Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Mail insurance claim forms to: \_\_\_\_\_

#2 Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Mail insurance claim forms to: \_\_\_\_\_

Name and address of policy holder's employer: \_\_\_\_\_

\_\_\_\_\_ Policy holder's work phone: \_\_\_\_\_

### AUTHORIZATIONS AND AGREEMENTS:

Payment Policy and Cancellation Agreement: I understand that the office files my primary insurance as a courtesy, but the bill is MY responsibility. I am aware that notice of cancellation must be given 24 hours in advance so that I will not be charged.

Patient's Signature: \_\_\_\_\_

Release of Information and Assignment of Benefits Agreement: I authorize Joseph M. Ripperger, MD & Associates to release any information acquired in the course of my treatment to my insurance company and assign the insurance payment due to me Joseph M. Ripperger, MD & Associates.

Patient's Signature: \_\_\_\_\_

## PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications on PHI be made by alternative means, such as sending correspondence to the your office instead of your home.

**I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Check all that apply):**

\_\_\_\_\_ Home Telephone \_\_\_\_\_

\_\_\_\_\_ O.K. to leave message with detail information

\_\_\_\_\_ Leave message with call-back number only

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ O.K. to leave message with detail information

\_\_\_\_\_ Leave message with call-back number only

\_\_\_\_\_ Work Telephone \_\_\_\_\_

\_\_\_\_\_ O.K. to leave message with detail information

\_\_\_\_\_ Leave message with call-back number only

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Parent or Guardian

(If patient is under 18 years old)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to the uses or disclosures made pursuant to an authorization requested by the individual.

**NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:** A complete description of how my medical information will be used and disclosed by Joseph M. Ripperger & Associates is in the "Notice of Privacy Practices." A copy of the "Notice of Privacy Practices" is posted in the clinical site and is available if you would like a copy.

I have accepted a copy of "Notice of Privacy Practices" Yes \_\_\_\_\_ No \_\_\_\_\_

Reason for the refusal, if No \_\_\_\_\_

## ADVANCE BENEFICIARY NOTICE

PATIENT NAME: \_\_\_\_\_

**NOTE: You need to make a choice about receiving these healthcare items or services.** Medicare/Private Insurance will not pay for the item(s) or service(s) that are described below. They do not pay for all of your health care costs. They only pay for covered items and services when Medicare/Private Insurance rules are met. The fact that Medicare/Private Insurance will not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case:

**MEDICARE/PRIVATE INSURANCE DOES NOT PAY FOR THESE SERVICES:**

- **Prior Authorization Request**
- **Letters/Forms Completed**
- **Patient Assistance for Medication**
- **Phone Sessions**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, known, that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare/Private Insurance won't pay.
- Ask us how much these items or services will cost you. **(Estimated Cost: \$20.00)**

<p>_____ <b>OPTION 1. YES. I WANT TO RECEIVE THESE ITEMS OR SERVICES</b></p> <p>I understand I will be responsible for payment of these services.</p> <p>_____ <b>OPTION 2. NO. I DO NOT WANT TO RECEIVE THESE ITEMS OR SERVICES.</b></p>
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\_\_\_\_\_  
Signature of patient or legal guardian

\_\_\_\_\_  
Date

<p><b>NOTE:</b> Your health information will be kept confidential. Any information that we collect on this form will be kept confidential in our office.</p>
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**INFORMED CONSENT, CONFIDENTIALITY, DESCRIPTION OF SERVICES**

**Description of Services:**

It is my understanding that Joseph M. Ripperger, M.D. is a licensed Psychiatrist, qualified in Oklahoma to practice medicine and provide psychotherapy. Counseling and psychotherapy involve discussing in detail my concerns, giving background information, and talking about areas that may cause me emotional pain, all for the purpose of trying to develop new and more effective methods of coping with problem areas in my or my child’s life. I understand that I am free to withdraw from therapeutic contact at any time if I so desire and will only be responsible to pay for the completed sessions.

**Confidentiality:**

All services provided and all information obtained is kept confidential and cannot be released without your written permission. You need to know, however, that there are special situations under which confidential information could be revealed such as:

1. A “duty to warn” ethic allows a psychiatrist to break confidentiality when danger exists to the patient or others.
2. Under special circumstances, the court may subpoena patient records and may order a psychiatrist to give testimony during a court hearing.
3. Third party payers, such as insurance companies, have a right to review patient’s records prior to payment.
4. Delinquent accounts may be turned over to a Collections Agency.
5. Based on clinical judgment, consultation with another professional with respect to your treatment may be sought.
6. Actual or suspected abuse to children or the elderly must be reported to authorities.

Your signature indicates that you have read and understood the above information concerning confidentiality and that you have read and understood the description of possible services, and consent is given to provide services to you and/or your child (or children), \_\_\_\_\_, who is (are) not of legal age.

PATIENT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATIONSHIP, IF PT IS MINOR

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

## **Financial Policy and Missed Appointment Policy**

*Please read over our financial and missed appointment policy. If you have questions, feel free to ask our staff.*

**Financial Policy Information:** Fees vary depending on what provider you are seeing and for what service. A brief list of some of the most common charges include:

<u>Dr. Ripperger:</u>	Initial evaluation: \$230, Medication Evaluation \$65-130 Therapy with Medication Evaluation \$110-\$230
<u>Amy Boggs, APRN-CNP &amp; Susan Thompson, APRN-CNP:</u>	Initial evaluation: \$190, Medication Evaluation: \$60-105 Therapy with Medication Evaluation: \$110-\$200
<u>Cameron Hollingsworth, LPC, LMFT &amp; Tony Wilson, M.Ed, LPC:</u>	Initial evaluation: \$150 Individual therapy \$80-\$130

**For Non-Medicare/Medicaid Patients Only:** A first-time patient is charged \$50 by credit card to hold their appointment time. This fee is non-refundable if you do not show up to your first appointment. It will be applied to your first appointment if the appointment is kept, or it will be credited to your account if your appointment is fully covered by your insurance.

**Insurance Patients.** If you have health insurance, our office is happy to call your insurance company and verify your insurance benefits. They will also file your insurance for you. If your insurance covers a portion of your therapy, we will wait for 90 days for them to pay their portion. However, you will be responsible for your deductible and co-pays. That portion of your care will be due at the time of your appointment. You will be responsible for all charges not covered by your insurance company. Any outstanding balance that has not been paid off in 90 days will be charged to your credit card on file. If for some reason this is not possible, you will be billed what you owe. If this is not paid within 30 days from that date, your account will be turned over to a collection agency.

**Self-Pay Patients.** Patients without insurance or with high deductibles are responsible for the cost of their care. Payment is expected at the time the service is rendered.

**Methods of Payment.** We accept cash, checks, and major credit cards.

**Missed Appointment Policy.** A full twenty-four hours is required for the cancellation of an appointment. Appointments canceled with less than 24 hours notice will be charged the full fee at rates shown above. Appointments missed due to inclement weather will not be charged. Your charge will be applied to your credit card on file.

**I have read and agree to the above conditions.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **Credit Card Guarantee for Personal Balance**

The credit card guarantee ensures that your account stays up-to-date and current. Your card will be kept on file and only used when payment has not been made by mail or in person. You can make co-pays, pay for special services, or pay your bill with your credit card on file, if you so choose. We will charge the amount due if payment has not been made in a timely manner. No show and/or cancellations made without 24 hours notice will be charged to your credit card on file.

### **( ) UNINSURED/SELF-PAY PATIENTS**

I understand that since I do not have insurance that I am personally responsible for payment. I understand that payment is due at the time of service.

### **( ) INSURANCE ASSIGNMENT**

I understand that as a courtesy to me, Dr. Ripperger & Associates will bill my health insurance carrier, but that my bill is MY responsibility. I understand that this office will wait up to 90 days for payment from my insurance provider. I understand that any amount owed after 90 days, which has not been paid by my insurance provider, will be placed on my designated credit card below. Any insurance payments made on these claims thereafter will be placed on my account as a credit or will be refunded to me, if I so choose.

I understand that if my insurance does not cover the cost of mental health treatment, if my deductible is high, or there are other limitations in my coverage, that I will be responsible for my bill at the time of service.

I agree to the above terms and authorize you to charge any payment not paid by the date due.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

CREDIT CARD: Circle One    Visa    Mastercard    Discover

CARD HOLDER'S NAME: \_\_\_\_\_

CARD HOLDER'S BILLING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

CARD #: \_\_\_\_\_ EXP. DATE: \_\_\_\_\_ THREE DIGIT CID NUMBER: \_\_\_\_\_

## SELF-ASSESSMENT FORM

### Please Print

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

With whom do you live (relationship, if any)? \_\_\_\_\_

Religion: \_\_\_\_\_

Education: (Highest level completed) \_\_\_\_\_ Degree, if any: \_\_\_\_\_

Occupation: \_\_\_\_\_

#### **Marital History:**

If you have been married, how many times? \_\_\_\_\_ If you have been divorced, how many times? \_\_\_\_\_

#### **Current Marital Status:**

Never married: \_\_\_\_\_ Married: \_\_\_\_\_ Living cooperatively: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_

**Emergency Contact:** Name of person to call in an emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name of person filling out form, if not patient: \_\_\_\_\_

#### **Medical Care:**

Who is your primary care physician? \_\_\_\_\_ Phone: \_\_\_\_\_

Are you are currently doing therapy with anyone else? If so, who? \_\_\_\_\_

**Please state the principal reason you are requesting a consultation or treatment:**

**JOSEPH M. RIPPERGER, M.D. & ASSOCIATES**  
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**Please describe your illness from the time of your first symptom to the present. Provide as many dates, names, and addresses of psychiatrists, psychologists, and/or social workers you have seen. Also, please provide the kinds of treatment you have received:**

**Please briefly describe any expectations you or your family members may have regarding treatment:**

**Suicide:**

Have you ever thought about suicide? Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes", when was the last time? \_\_\_\_\_

Have you ever attempted suicide? Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes", when and how? \_\_\_\_\_

Do you have thoughts about suicide now? Yes \_\_\_\_\_ No \_\_\_\_\_

**Recent stressful life events:**

(Check any of the following that have occurred in the last 1-year)

**Comments**

<input type="checkbox"/> married	_____
<input type="checkbox"/> engaged	_____
<input type="checkbox"/> separated	_____
<input type="checkbox"/> divorced	_____
<input type="checkbox"/> breakup of important relationship	_____
<input type="checkbox"/> child left home	_____
<input type="checkbox"/> death of spouse, or other loved one	_____
<input type="checkbox"/> bad health (behavior) of family member	_____
<input type="checkbox"/> personal injury, illness	_____
<input type="checkbox"/> changes at school, work	_____
<input type="checkbox"/> retired, lost job	_____
<input type="checkbox"/> changed residences	_____
<input type="checkbox"/> legal difficulties, multiple traffic tickets	_____
<input type="checkbox"/> owe money	_____
<input type="checkbox"/> traumatic experience(s)	_____

**Alcohol use:**

Do you drink Alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many drinks do you consume in an average day? \_\_\_\_\_ Week? \_\_\_\_\_

In the past 12 months, have you had 3 or more alcoholic drinks within a 3-hour period on 3 or more occasions? Yes \_\_\_\_\_ No \_\_\_\_\_

Was there ever a time when you felt you were, or someone told you, you were drinking too much? Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes" under what circumstance? \_\_\_\_\_

**Drug Use:**

Check any drugs you have taken. List the circumstances and pattern of use, or any consequences to the use. Also state the amount you used at its heaviest, and the last time you used.

<input type="checkbox"/> none	_____
<input type="checkbox"/> marijuana	_____
<input type="checkbox"/> amphetamine/speed	_____
<input type="checkbox"/> heroin/opiates	_____
<input type="checkbox"/> PCP	_____
<input type="checkbox"/> LSD/hallucinogens	_____
<input type="checkbox"/> cocaine/crack	_____
<input type="checkbox"/> barbiturates/sedatives/ downers	_____
<input type="checkbox"/> purchased prescriptions/ controlled substances via the internet	_____
<input type="checkbox"/> other	_____

**Past History:**

	COMMENTS
Check if during childhood you...	
<input type="checkbox"/> were afraid to go to school	_____
<input type="checkbox"/> had difficulty with reading, writing, or math	_____
<input type="checkbox"/> were truant	_____
<input type="checkbox"/> failed or repeated a grade	_____
<input type="checkbox"/> wet bed after age 5	_____
<input type="checkbox"/> had tics	_____
<input type="checkbox"/> had stutter/stammer	_____
<input type="checkbox"/> nightmares, disturbed sleep, fear of the dark.	_____
<input type="checkbox"/> ran away from home	_____
<input type="checkbox"/> were cruel to animals	_____
<input type="checkbox"/> frequently lied to families or others.	_____
<input type="checkbox"/> set fires.	_____
<input type="checkbox"/> moved frequently	_____
<input type="checkbox"/> were exposed to incest	_____
<input type="checkbox"/> worried excessively about your appearance	_____

**Family History:**

Please list all psychiatric illnesses (include **depression, bipolar disorder, anxiety, substance abuse, suicide attempts**, etc.). Indicate their relationship to you (mother, father, child, grandparent, aunt, uncle, sibling, etc), age, and age at death if deceased.

Relationship	Age	Age at death if deceased	Psychiatric illnesses
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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_____	_____	_____	_____
_____	_____	_____	_____

**JOSEPH M. RIPPERGER, M.D. & ASSOCIATES**  
**WEBSITE NEW PATIENT PACKET**

**Health History:**

**Weight**

What is your current weight in pounds? \_\_\_\_\_

Has your weight increased or decreased by more than 10 pounds in the last year: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain circumstances:

**Sleep** Do you:

Have difficulty falling asleep? Yes \_\_\_\_\_ No \_\_\_\_\_

Have difficulty staying asleep? Yes \_\_\_\_\_ No \_\_\_\_\_

Experience excessive daytime sleepiness? Yes \_\_\_\_\_ No \_\_\_\_\_

Snore or wake up short of breath or with a headache? Yes \_\_\_\_\_ No \_\_\_\_\_

Jerk or have restless legs in your sleep? Yes \_\_\_\_\_ No \_\_\_\_\_

**Smoking**

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, do you want to quit? Yes \_\_\_\_\_ No \_\_\_\_\_

**Caffeine**

Do you drink caffeinated coffee, tea, or colas? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you believe you are sensitive to caffeine? Yes \_\_\_\_\_ No \_\_\_\_\_

**Sexual Functioning**

Active? Yes \_\_\_\_\_ No \_\_\_\_\_

Satisfied with libido or your level of desire? Yes \_\_\_\_\_ No \_\_\_\_\_

Satisfied with functioning? Yes \_\_\_\_\_ No \_\_\_\_\_

**Allergies**

**List all allergies. Be sure to include medication allergies.**

**Medical Problems**

List all past and present medical problems as well as any surgeries or accidents. Please list the age of onset or occurrence.

**JOSEPH M. RIPPERGER, M.D. & ASSOCIATES**  
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**Check if you have had:**

\_\_\_\_ Head injury    \_\_\_\_ CAT scan or MRI of the brain    \_\_\_\_ Seizure    \_\_\_\_ EEG    \_\_\_\_ Neurological exam

**Current Medications:**

(Include prescriptive, herbal and over-the-counter medications)

Name	Dosage and frequency	Physician	How long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please List Your Preferred Pharmacy:

Name: \_\_\_\_\_ City: \_\_\_\_\_ Phone number: \_\_\_\_\_





**Review of Systems**

<b>Constitutional</b>	<b>Yes</b>	<b>No</b>	<b>Respiratory</b>	<b>Yes</b>	<b>No</b>	<b>Hematology Lymph</b>	<b>Yes</b>	<b>No</b>
Weight loss			Cough			Easy Bruising		
Fatigue			Coughing Blood			Bleeding gums		
Fever			Wheezing			Enlarged glands		
<b>Eyes</b>			Chills			<b>Musculo- skeletal</b>		
Glasses/ Contacts			<b>Gastro- Intestinal</b>			Joint Pain/ Swelling		
Eye Pain			Heartburn/ Reflux			Stiffness		
Double vision			Nausea/ Vomitting			Muscle Pain		
Cataracts			Constipation			Back Pain		
<b>Ear, Nose, Throat</b>			Change in BMs			<b>Skin</b>		
Difficulty hearing			Diarrhea			Rash/Sores		
Ringing in the ears			Jaundice			Lesions		
Vertigo			Abdominal Pain			Itching/ Burning		
Sinus trouble			Black or Bloody Stools			<b>Neurological</b>		
Nasal stuffiness			<b>Genitourinary</b>			Loss of Strength		
Frequent sore throat			Burning/ Frequency			Numbness		
Cardiovascular			Nighttime Frequency			Headaches		
Murmur			Blood in Urine			Tremors		
Chest Pain			Erectile Dysfunction			Memory Loss		
Palpitations			Abnormal Discharge			<b>Addictive Behaviors</b>		
Dizziness			Bladder Leakage			Gambling		
Fainting Spells			<b>Allergic</b>			Shopping Spending		
Shortness of Breath			Hives/Eczema			Internet		
Difficulty lying flat			Hay Fever			Pornography		
Swelling ankles			<b>Psychiatric</b>			Sex		
<b>Endocrine</b>			Anxiety			Gaming		
Loss of hair			Depression			Food		
Heat/Cold Intolerance			Mood swings			Reviewed by:	<b>Date:</b>	