

APPOINTMENT PREP SHEET

Patient: _____ Date: _____ Provider: _____

TODAY'S SPOON LEVEL (your scale): ____ / ____ CURRENT PAIN LEVEL: ____/10

SECTION 1: PRIORITY ISSUES (Maximum 3)

What absolutely must be addressed today?

1. Issue: _____
Duration: _____ Severity Impact: _____ What I've
tried: _____

2. Issue: _____
Duration: _____ Severity Impact: _____ What I've
tried: _____

3. Issue: _____
Duration: _____ Severity Impact: _____ What I've
tried: _____

SECTION 2: CURRENT MEDICATIONS & SUPPLEMENTS

Include dosage, timing, and any issues

Prescription Medications:

Patterns from the last 4 weeks

[illegible]

SECTION 4: FUNCTIONAL IMPACT

How symptoms affect daily life

Energy Levels: Good days: ____/10 | Average: ____/10 | Bad days: ____/10

Activities I've had to stop/modify: _____

Work/Social impact: _____

SECTION 5: QUESTIONS FOR PROVIDER

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

SECTION 6: REQUESTS

Referrals needed: _____

Tests requested: _____

Prescription refills: _____

Documentation needed: _____

NOTES FROM APPOINTMENT:
