

**Nassau Psychiatric Services, P.C.**

601 Franklin Ave, Suite 120

Garden City, NY, 11530

Phone: (516) 280-9030

Fax: (516) 280-9029

Email: [assistant.ny@continentalpsychiatry.com](mailto:assistant.ny@continentalpsychiatry.com)

Website: [www.continentalpsychiatry.com](http://www.continentalpsychiatry.com)

**NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Patient's Information Form**

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Gender: \_\_\_\_\_

Address (Street #, City, Zip Code): \_\_\_\_\_

Phone Number: (H) \_\_\_\_\_ (C) \_\_\_\_\_

May we leave message? On your home phone number (  YES/  NO); on your cell phone number (  YES/  NO)

Emergency Contact (Name, DOB, Relationship): \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_

Others living at home (Name, DOB, Relationship to you and any relevant comments):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Have you been in therapy before: YES / NO.? If yes, when: \_\_\_\_\_

\_\_\_\_\_

Name of therapist: \_\_\_\_\_

Give brief description of issues worked on: \_\_\_\_\_

Referred by (therapist, physician, yellow pages, friend, etc.): \_\_\_\_\_

Pharmacy's name, complete address, phone number:  
\_\_\_\_\_

**Mother:** \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Phone Number: \_\_\_\_\_ May we leave a message?  Yes/  No

Address (if different that child): \_\_\_\_\_

May we mail to this address?  Yes/  No

Place of Employment: \_\_\_\_\_ Highest Degree Earned: \_\_\_\_\_

**Father:** \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Phone Number: \_\_\_\_\_ May we leave a message?  Yes/  No

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Address (if different than child): \_\_\_\_\_

May we mail to this address?  Yes/  No

Place of Employment: \_\_\_\_\_ Highest Degree Earned: \_\_\_\_\_

**Who has legal custody?**  Mother/  Father/  Joint

Other, please specify: \_\_\_\_\_

Is there a court order concerning custody?  Yes/  No

**If YES, please provide a copy of the court order.**

**If not the mother or the father, please complete the following:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

May we leave a message?  Yes/  No      May we mail to this address:  Yes/  No

What is your relationship to the child?

Is there a court order appointing you as guardian?  Yes/  No **If yes, please provide a copy of the court order.**

**Academic Information (if applicable):**

Current School: \_\_\_\_\_ Grade: \_\_\_\_\_

GPA: \_\_\_\_\_ Are there any problems at the school?  Yes/  No      If yes, please describe:

\_\_\_\_\_

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**Authorization for Treatment**

I hereby authorize Nassau Psychiatric Services, P.C. and the providers affiliated to the practice, to give and/or administer psychiatric and medical treatment and any appropriate patient care services which, in their judgment becomes necessary to my care.

Patient or Guardian Signature

Relationship to Patient

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**Patient's Financial Responsibility Form (1 of 2)**

I authorize payments of medical benefits to Nassau Psychiatric Services, P.C. for services rendered.

Payment in full for services are due at the time services are rendered. Co-payments will be collected at the time of service. Professional fees, services fees, co-payments and deductibles are non-refundable. There will be a \$20 fee for returned checks.

In divorce situations, the parent who brings in the child/ children is obligated to pay the session fee or copayment/ deductible, even if he/she is not the policy holder. The parent bringing the child/ children to the session is responsible for sharing the information with the other parent. If the other parent would like to schedule a session to discuss the progress of the child/ children, the usual session fee is charged and must be paid at the time of the appointment.

I understand and agree that I am financially responsible for all charges for all services rendered.

This includes any medical service or visit, and any other screenings, procedures or tests ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered.

I understand that I am responsible for any services or charges that are determined by my insurance carrier not to be medically necessary.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

I understand that I need to provide the office both my primary and my secondary insurance ID card, if applicable. If the office does not have the proper information for a secondary insurance, the secondary insurance will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

We will bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance.

**Questions about non-payment or about any invoices received from our office, should be directed to your insurance company.**

If you are unable to keep your scheduled appointment, we ask that you give adequate notice of 24 hours prior to your appointment time, so that we may open your reserved time for another patient. There will be a \$50.00 charge if you don't provide the office a 24-hour notice of cancellation. If you miss two appointments without proper notice, you will be required to pay a \$50.00 deposit prior to scheduling further appointments. This is a good-faith deposit to reserve your appointment time.

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**DOB:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Patient's Financial Responsibility Form (2 of 2)**

When the appointment is kept, this \$50.00 fee will be applied to your office visit fees or refunded as appropriate. If the appointment is missed without proper notice of cancellation, the deposit becomes non-refundable.

The patient understands:

- Protected health information may be disclosed or used for treatment, billing, health care operations and/or as required by law.
- Nassau Psychiatric Services, P.C. has a summary Notice of Privacy Practices, and the patient can review this notice.
- The patient has the right to be informed when their PHI is believed to have been breached.
- The patient is allowed to restrict PHI disclosure to their health plan if the patient is agreeing to pay out of pocket and in full for services rendered.

The doctors and staff of Nassau Psychiatric Services, P.C. appreciate your compliance with these policies and procedures. We strive to provide the best mental health available to you. We are happy to discuss any questions or concerns you have about these policies.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Nassau Psychiatric Services, P.C. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient's or Guardian's Signature: \_\_\_\_\_

Nassau Psychiatric Services, P.C. Witness: \_\_\_\_\_

I give permission to communicate my Private Healthcare Information (PHI) to:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

The authorization to communicate patient's PHI will be valid until expressly revoked by the patient.

*Our office does not make the rules. They are determined by your specific medical insurance.*

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**Authorization for Coordination of Care**

To complete your psychiatric evaluation, it is crucial for your clinician to review your most recent physical examination, blood work, EKG and any other pertinent medical information.

Please fill out and sign this form to authorize your clinician to exchange information regarding your medical and behavioral health condition to your primary care physician and any other behavioral health provider who may be directly involved in making decisions regarding your healthcare. This authorization will remain in effect indefinitely, as it is necessary for coordination and continuation of care purposes.

Please notify your behavioral health provider whenever you change your primary care physician.

I authorize NASSAU PSYCHIATRIC SERVICES P.C. and its medical providers to exchange information, written or verbal, with each other and/or to the person(s) or organization(s) listed below for ongoing coordination of care:

1. Primary care physician (name, address, phone and fax number):

Name: \_\_\_\_\_ Title: \_\_\_\_\_

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

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

2. Other behavioral healthcare provider involved in treatment, e.g., psychiatrist or psychotherapist/ psychologist (name, address, phone, and fax number):

Name: \_\_\_\_\_ Title: \_\_\_\_\_

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

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

**Patient's or Guardian's signature:** \_\_\_\_\_

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### Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> Discover <input type="checkbox"/> AMEX Other _____
Cardholder Name (as shown on card): _____
Card Number: _____, V code: _____ (security code on the back of the card)
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I authorize Nassau Psychiatric Services, P.C. to charge my credit/debit card above for the amount corresponding to my deductible, coinsurance, copayments, or any other patient's financial responsibility as per my insurance carrier benefits.

I understand that my information will be saved to file for future transactions on my account.

\_\_\_\_\_  
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**Acknowledgement of Receipt of HIPPA Notice of Private Practices and Practice Policy**

*By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and therefore been advised of how health information may be used and disclosed. I also acknowledge that I reviewed and fully understand the Practice Policy and Payment Policy. I agree to abide by the terms and conditions of this Agreement and to consent to participate in psychotherapy and or psychiatric treatment at Nassau*

*Psychiatric Services, P.C.*

\_\_\_\_\_  
Patient's or Guardian's Signature

\_\_\_\_\_  
Description of Personal Representative Authority

\*\*\*\*\*

**(For internal use – where signature above cannot be obtained)**

Except in emergency treatment circumstances, the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that we make a good effort to obtain written acknowledgment of the patient's receipt of the Notice of Privacy Practices on the first date after April 14, 2003, we provide treatment, products or services to the patient. We must make a good faith effort to obtain written acknowledgment when reasonably practicable following an emergency treatment situation. If such acknowledgment cannot be obtained, we must document our good faith efforts to obtain the acknowledgment and why it was not obtained

Describe good faith efforts to obtain written acknowledgment

1. \_\_\_\_\_

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

2. \_\_\_\_\_

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



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**INFORMED CONSENT FOR THE USE OF EMAIL**

Patients who wish to communicate with their therapist or psychiatrist and/or administrative staff using email, are welcome to do so. However, there are several privacy concerns and potential risk factors that should be considered before transmitting confidential information by email.

General concerns include email is immediately broadcast worldwide and can be received by unintended recipients; emails messages can be forwarded without sender’s or intended recipient’s permission or knowledge; emails can easily be misaddressed; back-up copies of emails may exist after the sender, or the recipient has deleted them; and email is easier to falsify than documents that are signed and sent by regular mail.

Privacy concerns related to a one’s personal health information also need to be considered. It is the policy of our office to make all email messages concerning diagnosis and/or treatment part of that client’s medical record and to treat these with the same degree of confidentiality as other portions of the medical record. We take all reasonable means to protect clients’ confidentiality but cannot guarantee the security and confidentiality of email communication. Please read the following information outlining our office’s conditions for the use of email.

- We cannot guarantee that electronic communications will be private. We take reasonable steps to protect confidentiality but is not liable for improper disclosure of confidential information not caused by negligence or misconduct.
- If the client chooses to use email, the client is responsible for informing our office of any limitations to the kind of information that will be sent by email.
- The client is responsible for protection of their own password or other means of access to email sent or received. We are not liable for breaches of confidentiality caused by the client.
- Because employees do not have a right of privacy in their employer’s email system, clients should not use their work/business system to send or receive confidential medical information.
- When an email is received by the therapist /psychiatrist or administrative staff person there will be an attempt made to read it promptly and, when appropriate, respond. However, we cannot assure a specific time frame and suggests sending a follow-up email or phone call if some time has passed.
- Emails concerning diagnosis and/or treatment become part of the client’s medical record and is available to certain authorized entities such as health care providers and insurers for the purpose of treatment and reimbursement. While emails may be forwarded with the agency for these purposes, we will not forward the email outside the agency without the consent of the client or as required by law.
- **Email should not be used when transmitting sensitive medical information.**
- **Email should not be used in the case of a medical emergency.**

I have read the above privacy concerns and conditions for the use of email and consent to the use of email for communications.

\_\_\_\_\_  
Patient’s or Guardian's Signature

\_\_\_\_\_  
E-mail address

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## **Informed Consent for use of Telemedicine Platform**

I consent to the use of Telemedicine Platform, for the purpose of participating in the evaluation and/ or treatment with Nassau Psychiatric Services, P.C.

I am aware of the potential risks and consequences of holding the session via phone, Facetime, Skype, or any other HIPAA non-compliant platform, in the situation I will choose to use a HIPAA non-compliant platform. I understand that legitimate concerns exist about privacy, security, patient safety and interoperability and I will not hold Nassau Psychiatric Services, P.C. (DBA Continental Psychiatry) and its providers liable for information that was shared over the internet due to Telemedicine Platform connection, and without their knowledge. I agree to comply with the requirements provided below, and that I will abide by Nassau Psychiatric Services, P.C.'s cancelation policy for Telemedicine consultations. (24-hour notice is required in order to avoid additional charges.)

Patient's or Guardian's Signature: \_\_\_\_\_

### **What the patient needs to do and know prior of holding a telemedicine session with their provider:**

1. Create a client portal upon invitation from Nassau Psychiatric Services, P.C.
2. Payments for telemedicine sessions need to be made upfront, through the client portal or simply call Nassau Psychiatric Services, P.C. office to process the payment over the phone.
3. Some insurance companies may limit your benefits for the use of telemedicine. We suggest that you call your insurance company in advance to ask about your policy, benefits and plan of limitations, as you might be responsible for the full amount of the session.

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**Medical Information Form**

*Please provide an answer to all the below questions or write NA (Not Applicable)*

Pregnancy and Birth History:  Full term/  Premature/  Adopted

If adopted, please provide details:

\_\_\_\_\_  
\_\_\_\_\_

Please list any unusual circumstances during the child's first 5 years (e.g., separation/ divorce, deaths in family, etc.):

\_\_\_\_\_  
\_\_\_\_\_

Please list child's current medical problems, serious medical illness, accidents, surgeries or operations, hospitalizations (Identify each of them and provide dates if applicable):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Primary Care Physician Information**

Your last appointment with your Primary Care Physician (date): \_\_\_\_\_

Last blood work done (date): \_\_\_\_\_

Current Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_

Have you been under **psychiatric care** before? If yes, please provide name of your counselor or psychiatrist, the dates of treatment, the reason and any other pertinent information regarding the treatment and/ or discontinuation of treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Please list **any current medications** and provide the following information.

Please write N/A, if you aren't taking any medications at this time.

Medication Name & Dosage	Prescribing Provider

Please list **any past psychiatric medications** and provide the following information.

Please write N/A, if you weren't prescribed any psychiatric medications in the past.

Medication Name & Dosage	Start Date	End Date	Response/ Side Effects

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Do you have **allergies to any medications**? If yes, please mention to which medications and describe.

If no, please write N/A.

Medication Name	Response/ Describe

Primary Reason/ Chief Complaint for visiting Nassau Psychiatric Services, P.C.:

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	<b>Now</b>	<b>Past</b>	<b>Never</b>	<b>Family History</b>	<b>What treatment received and date</b>
<b>Abscesses</b>					
<b>Anemia</b>					
<b>Arthritis</b>					
<b>Asthma</b>					
<b>Bleeding Disorder</b>					
<b>Blood pressure (high or low)</b>					
<b>Bone/Joint problem</b>					
<b>Cancer</b>					
<b>Cirrhosis/Liver disease</b>					
<b>Diabetes</b>					
<b>Drug Overdose</b>					
<b>Endocarditis</b>					
<b>Epilepsy/Seizures</b>					
<b>Eye disease/Difficulties</b>					
<b>Fibromyalgia/Muscle pain</b>					
<b>Headaches</b>					
<b>Head injury/ Brain tumor</b>					
<b>Hearing Problems/deafness</b>					
<b>Heart Disease</b>					
<b>Hepatitis (type?)</b>					
<b>Kidney Disease</b>					
<b>Lung Disease</b>					
<b>Menstrual Pain</b>					
<b>Oral health/Dental</b>					
<b>Sickle Cell Anemia or Trait</b>					
<b>Stomach/Bowel movement</b>					
<b>Stroke</b>					
<b>Thyroid</b>					
<b>Tuberculosis</b>					
<b>AIDS/HIV</b>					
<b>Sexually Transmitted Diseases</b>					
<b>Eating Disorder</b>					
<b>Sleep Difficulties</b>					
<b>Other</b>					

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## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

Not at all

Several  
days

More than  
half the day  
s

Nearly every  
day

1. Little interest or pleasure in doing things

2. Feeling down, depressed, or hopeless

3. Trouble falling or staying asleep, or sleeping too much

4. Feeling tired or having little energy

5. Poor appetite or overeating

6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down

7. Trouble concentrating on things, such as reading the newspaper or watching television

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual

9. Thoughts that you would be better off dead or of hurting yourself in some way

**Total Score:** \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ = \_\_\_\_\_

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all    Somewhat difficult    Very difficult    Extremely difficult

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## The Mood Disorder Questionnaire

**Instructions:** Please answer each question to the best of your ability.

<b>Has there ever been a period of time when you were not your usual self and...</b>	<b>YES</b>	<b>NO</b>
... you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?	<input type="checkbox"/>	<input type="checkbox"/>
... you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
... you felt so much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
... you got much less sleep than usual and found you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
... you were much more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
... thoughts raced through your head, or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
... you were so easily distracted by things around you that you had trouble concentration or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
... you had much more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
... you were much more active and did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
... you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
... you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="checkbox"/>	<input type="checkbox"/>
... spending money got you or your family into trouble?	<input type="checkbox"/>	<input type="checkbox"/>
<b>If you checked YES to more than one of the above, have several of these ever happened during the same period of time?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>How much of a problem did any of these cause you- like being unable to work; having family, money or legal troubles; getting into arguments or fights?</b> <i>Please circle one response only.</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>No Problem.</b> <input type="checkbox"/> <b>Minor Problem.</b> <input type="checkbox"/> <b>Moderate Problem.</b> <input type="checkbox"/> <b>Serious Problem.</b> <input type="checkbox"/>		
<b>Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?</b>	<input type="checkbox"/>	<input type="checkbox"/>



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

DOB: \_\_\_\_\_

DATE: \_\_\_\_\_

**Beck Anxiety Inventory (BAI)**

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by checking the corresponding space in the column next to each symptom.

	<b>Not At All</b>	<b>Mildly- it didn't bother me much</b>	<b>Moderately- it wasn't pleasant at times</b>	<b>Severely- it bothered me a lot</b>
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling hot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wobbliness in legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear of worst happening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy or lightheaded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart pounding/ racing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unsteady	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Terrified or afraid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shaky/ unsteady	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear of losing control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear of dying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Faint/ lightheaded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Face flushed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot/ cold sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>