

Dear New Patient:

Welcome. Enclosed is the New Patient Packet you have requested. Please fill out the Questionnaires and Medical Information Forms and return it our office. New patients cannot be seen without this information. Upon receipt of the Packet, we will contact you to make your first appointment. Complete these forms as fully as you can, even if you are not sure of all the answers. The Diagnostic Tests and Treatment Forms are especially important as they will guide us in your treatment planning. If you have a single, straightforward health problem, you may skip the questions that are not relevant. However, most people's problems are inter-related and relatively complex, so a full history is important.

If possible, please send or bring copies of previous Laboratory or X-Ray reports, especially if the results were abnormal. (Usually, the reports are enough. We do not need the actual X-Ray films.) Because of the time set aside for your Initial Visit and the time spent to review your case in advance, we require a \$150.00 Non-Refundable deposit to hold your appointment (attach payment to your completed Patient Packet and return it to our office). Your deposit will be deducted from your Initial Visit fee.

New Patient visits are at least 1 ½ hours. The fee for an Initial Visit is \$690.00 with Dr. Podell. Payment is required at the time of service. This includes a comprehensive review of your medical history and a detailed explanation of treatment options and recommendations. Dr. Podell's initial evaluation and treatment phase typically consists of a comprehensive initial visit and then two or three monthly follow up visits, costing \$200.00 per visit. After that, visits are as needed.

Dr. Podell does not participate with any Health Insurance Plans, including Medicare/Medigap programs. We will, however, provide you with a receipt that you can submit to your insurance plan (other than Medicare/Medigap) for possible reimbursement. Dr. Podell's referrals for laboratory work, x-rays, etc. are typically covered by Medicare/Medigap since the providers of these services are usually Medicare participants.

Edwina (Wendy) King, PhD, APRN is an advanced practice nurse – a nurse practitioner, not a physician. Dr. King is an independent practitioner who heads our pediatric and adult behavioral science program including autistic spectrum disorders. Dr. King is a Medicare participant and uses the standard Medicare fee schedule. Dr. King does not participate with any Commercial Health Insurance Plans, but we will provide you with a receipt that you can submit to your insurance plan for possible reimbursement. Please refer to Dr.King's website [DrKing.org](http://DrKing.org) for more information about her practice and these programs.

We now have two locations in New Jersey: Summit 11 Overlook Road, Suite 140, Medical Arts Bldg. II (MAC II), Summit, NJ 07901, Tel: 908-273-7770, Fax: 908-273-7788 and the New Brunswick area 53 Kossuth Street, Somerset, NJ 08873, Tel: 732-565-9224.

We wish you well in your process of healing and look forward to working with you.

Yours truly,  
Richard N. Podell, MD and Edwina (Wendy) King, PhD, APRN  
Beverly Licata, RN/Nurse Educator



# HEADACHE AND MIGRAINE HEALTH HISTORY QUESTIONNAIRE

Your Name \_\_\_\_\_

Date \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Tel: \_\_\_\_\_ E-mail: \_\_\_\_\_

Work Tel: \_\_\_\_\_ Cell: \_\_\_\_\_

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

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

How Did You Hear Of Us? Doctor \_\_\_ WOR Radio \_\_\_ Internet \_\_\_ Friend \_\_\_ Other \_\_\_

Referred By: \_\_\_\_\_ Address: \_\_\_\_\_

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

Tel: \_\_\_\_\_

## SECTION I: OVERVIEW

1) My Most Important Problem Is: \_\_\_\_\_

2) What have other doctors thought was the main cause or diagnosis?

3) Do you agree? Yes, largely \_\_\_ Yes, partly \_\_\_ No \_\_\_

What do you think is likely to be the main problem or diagnosis (or aspect of your problem that might have been overlooked)? \_\_\_\_\_

What kind of approaches do you feel might be most useful to look further at now?

Are you allergic to any medicines (which meds?, what happens?)

Are you allergic to any foods (which, what happens) e.g. wheat \_\_\_ gluten \_\_\_ milk/dairy \_\_\_ eggs \_\_\_ alcohol \_\_\_ others \_\_\_\_\_

Are you allergic to Dust/dust mite \_\_\_ Cat \_\_\_ Other pets \_\_\_ Mold \_\_\_ Trees \_\_\_ Grasses \_\_\_ Ragweed \_\_\_\_\_

Do you suspect that environmental factors at home or at work might be contributing to your symptoms. If so, where and why? \_\_\_\_\_

## Health Problems and Priorities

Your Health Problem	Severity 0-10 10 is worst	About when first became a problem?	Worse During Past Year?	Worse During Past Months?	Priority for our visits A=highest B= medium C= not high priority
MIGRAINE HEADACHE					
TENSION HEADACHE					
OTHER HEADACHE					
NECK PAIN					
FATIGUE-poor exercise tolerance					
FATIGUE-decent exercise tolerance					
DIFFUSE MUSCLE PAIN OR FIBROMYALGIA					
JOINT PAINS					
DEPRESSION					
ANXIETY/STRESS					
WEIGHT GAIN					
WEIGHT LOSS					
GI UPSETS					
SINUS/NASAL OR ALLERGY					
LYMPH GLANDS					
THYROID					
HORMONES					
OTHER					

## HEADACHE HISTORY (For Your Most Important Headache)

Do you have more than one type of Headache? *Briefly describe main headache and then other headaches here:*

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1. Are you ever free of headaches? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If Yes, when? Pregnancy \_\_\_\_\_ Vacation \_\_\_\_\_ Weekends \_\_\_\_\_ Random \_\_\_\_\_  
 Periods of remission \_\_\_\_\_ Other \_\_\_\_\_

2. Onset of First Headache:  
 Headache started \_\_\_\_\_ years ago. I was \_\_\_\_\_ years old.  
 Headache has become substantially more severe in the: Last few months? \_\_\_\_\_  
 Last year \_\_\_\_\_ Last several years \_\_\_\_\_  
 Has been about the same for a long time \_\_\_\_\_

**For your Most Important Headache (cont.)**

3. Precipitating Event (what provoked your first headache):

None known \_\_\_\_\_ Injury \_\_\_\_\_

First Period \_\_\_\_\_ Pregnancy \_\_\_\_\_

Other \_\_\_\_\_

4. Current Pattern: Sudden \_\_\_ Rapid \_\_\_ Gradual \_\_\_ Varies \_\_\_\_\_

Time of day: Morning \_\_\_ Afternoon \_\_\_ Evening \_\_\_ Night \_\_\_\_\_

Relation to Sleep: Awakens from Sleep \_\_\_ Rarely if ever wakes me from sleep \_\_\_\_\_

Other \_\_\_\_\_

5. Are they substantially more frequent or more severe on: Weekends \_\_\_

Weekdays \_\_\_ Vacation \_\_\_ Summer \_\_\_ Fall \_\_\_ Winter \_\_\_ Spring \_\_\_\_\_

Other \_\_\_\_\_

Comments \_\_\_\_\_

6. Frequency (the number of attacks on average):

Per day \_\_\_\_\_ Per week \_\_\_\_\_ Per Month \_\_\_\_\_ Per Year \_\_\_\_\_ Continuous \_\_\_\_\_

Are they increasing in frequency? Yes \_\_\_ No \_\_\_ Not sure \_\_\_\_\_

Comments: \_\_\_\_\_

7. Duration (Typically how long do they last?)

Without Medication: minutes \_\_\_ hours \_\_\_ days \_\_\_\_\_ How often do they recur within 24 hours? \_\_\_\_\_

With Medication: minutes \_\_\_ hours \_\_\_ days \_\_\_\_\_ How often do they recur within 24 hours? \_\_\_\_\_

8. Severity (Usually, How bad is the pain on a scale of 0 to 10 with 0 being no pain and 10 being the worst)

Lowest level of pain typical for this headache \_\_\_\_\_

Most frequent level of pain for this headache \_\_\_\_\_

Highest Level of pain typical for this headache \_\_\_\_\_

Comments \_\_\_\_\_

9. Location (put one check if pain is typically mild. Put four checks if pain is typically severe. Check as many as apply)

Sidedness:

Mainly on the right \_\_\_ Mainly on the left \_\_\_ Often on both sides \_\_\_\_\_

Side varies from attack to attack \_\_\_\_\_ Side changes during attack \_\_\_\_\_

**For your Most Important Headache (cont.)**

Location (Put one check or one x if pain typically mild at this location. Put four checks or x's if pain is often severe at this location.)

Right Temple (side toward front) \_\_\_\_\_ Left Temple \_\_\_\_\_  
 Back of Head (occipital) \_\_\_\_\_ Back of neck \_\_\_\_\_ Ear \_\_\_\_\_ Jaw \_\_\_\_\_ Nose \_\_\_\_\_  
 Right side of neck \_\_\_\_\_ Left side of neck \_\_\_\_\_ Front of neck \_\_\_\_\_  
 Right side toward middle of head (parietal) \_\_\_\_\_ Left side toward middle of head \_\_\_\_\_  
 Top of head \_\_\_\_\_ In a circle around the head \_\_\_\_\_  
 In or behind Right Eye \_\_\_\_\_ In or behind Left Eye \_\_\_\_\_  
 Above the Eye (front temple) \_\_\_\_\_ Below the Eye (cheek bone) \_\_\_\_\_  
 All over the head \_\_\_\_\_  
 Comments \_\_\_\_\_

10. Characteristics (check as many as apply):

Throbbing/ pulsing \_\_\_\_\_ Pressure \_\_\_\_\_  
 Achy \_\_\_\_\_ Burning \_\_\_\_\_  
 Tight \_\_\_\_\_ Searing \_\_\_\_\_  
 Dull \_\_\_\_\_ Shooting \_\_\_\_\_  
 Stabbing \_\_\_\_\_ Other \_\_\_\_\_

Comments: \_\_\_\_\_

11. Activity That Bring On or Worsen Headache (Place one check or x for factors that mildly or only occasionally bring on or worsen headache. Place four checks or x's for factors that often or severely bring on or worsen headache.)

None \_\_\_\_\_ Walking \_\_\_\_\_ Climbing Steps \_\_\_\_\_ Exercise \_\_\_\_\_  
 Coughing \_\_\_\_\_ Talking \_\_\_\_\_ Clenching, chewing or moving Jaw \_\_\_\_\_ Turning  
 Head/Neck \_\_\_\_\_ Sleep (lack of) \_\_\_\_\_ Sleep (too much) \_\_\_\_\_ Sleep (disturbed)  
 Sexual Activity \_\_\_\_\_ Skipping Meals \_\_\_\_\_ Eating particular foods \_\_\_\_\_  
 Computer \_\_\_\_\_ Period or PMS \_\_\_\_\_ Pregnancy \_\_\_\_\_ Menopause \_\_\_\_\_  
 Emotional Distress \_\_\_\_\_ (work \_\_\_\_\_ home \_\_\_\_\_ family \_\_\_\_\_ spouse \_\_\_\_\_ Other \_\_\_\_\_  
 Alcohol \_\_\_\_\_ Too much caffeine \_\_\_\_\_ Not enough caffeine \_\_\_\_\_ Tobacco \_\_\_\_\_  
 Any Medicines \_\_\_\_\_ which? \_\_\_\_\_  
 Bright lights \_\_\_\_\_ Loud Noises \_\_\_\_\_ Smells/odors \_\_\_\_\_ season changes \_\_\_\_\_  
 Allergies \_\_\_\_\_ Weather changes \_\_\_\_\_ altitude \_\_\_\_\_, sunlight \_\_\_\_\_

Other triggers/Comments: \_\_\_\_\_

12. Headache Disability During or After an Attack

Normal activity \_\_\_\_\_ Slight decrease in function \_\_\_\_\_ Moderate decrease \_\_\_\_\_  
 Severe decrease in function \_\_\_\_\_ Confined to bed \_\_\_\_\_

## For your Most Important Headache (cont.)

### 13. Associated Symptoms

Nausea \_\_\_ Vomiting \_\_\_ Sensitivity to Light \_\_\_ Sensitivity to Sounds \_\_\_  
 Sensitivity to Odors \_\_\_  
 Diarrhea \_\_\_ Constipation \_\_\_ Insomnia \_\_\_ Increased Urination \_\_\_  
 Sore/stiff neck \_\_\_ Ringing in ears \_\_\_ Anxiety/Irritability \_\_\_ Depression \_\_\_  
 Concentration Problems \_\_\_ Memory Problems \_\_\_ Confusion \_\_\_  
 Increased appetite \_\_\_ Decreased appetite \_\_\_  
 Eye Tearing (Rt \_\_\_ Left \_\_\_ both \_\_\_) Drooping Eyelid (Rt \_\_\_ Left \_\_\_ Both \_\_\_)  
 Change in Pupil (larger \_\_\_ smaller \_\_\_)  
 Comments: \_\_\_\_\_

### 14. Aura: Visual (Do you often \_\_\_ ever \_\_\_ have these symptoms before your headache begins?)

Blurry vision \_\_\_ Tunnel vision \_\_\_  
 Flashing lights \_\_\_ Double vision \_\_\_  
 Zigzag lines \_\_\_  
 Loss of vision in one eye \_\_\_ loss of vision on one side \_\_\_ total blindness \_\_\_

Aura Sensory: (Do you often \_\_\_ ever \_\_\_ have these symptoms before your headache begins?)

Numbness/tingling right \_\_\_ Numbness/tingling left \_\_\_  
 Dizziness/unsteadiness \_\_\_ Vertigo (spinning) \_\_\_ Light headedness \_\_\_  
 Weakness on one side \_\_\_ General weakness \_\_\_ speech difficulty \_\_\_  
 Other \_\_\_\_\_

Does your aura spread? Yes, spreads slowly \_\_\_ No, begins all at once \_\_\_

### 15. Premonitory Symptoms (Do you experience one or more of these before onset of headache)

Increased feeling of wellness ___	Difficulty Concentrating ___
Hyperactive ___	Sensitive to light ___
Talkative ___	Sensitive to noise ___
Depressed feeling ___	Sensitive to odors ___
Irritable ___	Difficulty with speech ___
Sluggish ___	Yawning ___
Drowsy ___	Neck stiff ___
Restless ___	Food cravings ___
Dizzy ___	Weakness ___
Light headed ___	Feeling cold ___
Diarrhea	Increased appetite ___
Constipation	Decreased appetite ___
Extremely thirsty	Other _____
Increased urination	_____
Fluid retention	_____

## For your Most Important Headache (cont.)

### 16. Relieving Factors:

Lying down \_\_\_\_\_ Dark/quiet room \_\_\_\_\_ Lying down \_\_\_\_\_ Pregnancy \_\_\_\_\_  
Hot compress \_\_\_\_\_ Cold compress \_\_\_\_\_ Sleep \_\_\_\_\_ Keeping active \_\_\_\_\_  
Standing \_\_\_\_\_ Massage \_\_\_\_\_ Physical position \_\_\_\_\_

Medicines: Aspirin \_\_\_\_\_ Advil/Ibuprofen \_\_\_\_\_ Tylenol/acetaminophen \_\_\_\_\_  
Triptans (e.g. Imitrex) \_\_\_\_\_ If yes, which works best?  
Ultram \_\_\_\_\_ Codeine \_\_\_\_\_ Other narcotic pain meds \_\_\_\_\_  
Muscle relaxants/ tranquilizers e.g. Valium, e.g. Flexeril e.g. Skelaxin ) \_\_\_\_\_

Other medicines \_\_\_\_\_

Other/Comments: \_\_\_\_\_

\_\_\_\_\_

## HEADACHE HISTORY (Your Second Most Important Headache)

Briefly describe your second most important headache here: \_\_\_\_\_

\_\_\_\_\_

1. Are you ever free of headaches? Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes, when? Pregnancy \_\_\_\_\_ Vacation \_\_\_\_\_ Weekends \_\_\_\_\_ Random \_\_\_\_\_  
Periods of remission \_\_\_\_\_ Other \_\_\_\_\_

2. Onset of First Headache:  
Headache started \_\_\_\_\_ years ago. I was \_\_\_\_\_ years old.

Headache has become substantially more severe in the

Last few months? \_\_\_\_\_ Last year \_\_\_\_\_ Last several years \_\_\_\_\_  
Has been about the same for a long time \_\_\_\_\_

3. Precipitating Event (what provoked your first headache):

None known \_\_\_\_\_ Injury \_\_\_\_\_

First Period \_\_\_\_\_ Pregnancy \_\_\_\_\_

Other \_\_\_\_\_

4. Current Pattern: sudden \_\_\_\_\_ Rapid \_\_\_\_\_ Gradual \_\_\_\_\_ Varies \_\_\_\_\_  
Time of day: morning \_\_\_\_\_ Afternoon \_\_\_\_\_ Evening \_\_\_\_\_ Night \_\_\_\_\_  
Relation to Sleep: Awakens from Sleep \_\_\_\_\_ Rarely if ever wakes me from sleep \_\_\_\_\_  
Other \_\_\_\_\_

**For your Second Most Important Headache (cont.)**

5. Are they substantially more frequent or more severe on: Weekends \_\_\_ Weekdays \_\_\_  
Vacation \_\_\_ Summer \_\_\_ Fall \_\_\_ Winter \_\_\_ Spring \_\_\_ Other \_\_\_  
Comments \_\_\_\_\_

6. Frequency (the number of attacks on average):  
Per day \_\_\_ Per week \_\_\_ Per Month \_\_\_ Per Year \_\_\_ Continuous \_\_\_  
Are they increasing in frequency? Yes \_\_\_ No \_\_\_ Not sure \_\_\_  
Comments: \_\_\_\_\_

7. Duration (Typically how long do they last?)  
Without Medication: minutes \_\_\_ hours \_\_\_ days \_\_\_ How often do they recur  
within 24 hours? \_\_\_\_\_  
With Medication: minutes \_\_\_ hours \_\_\_ days \_\_\_ How often do they recur  
within 24 hours? \_\_\_\_\_

8. Severity (Usually, How bad is the pain on a scale of 0 to 10 with 0 being no pain and  
10 being the worst)  
Lowest level of pain typical for this headache \_\_\_\_\_  
Most frequent level of pain for this headache \_\_\_\_\_  
Highest Level of pain typical for this headache \_\_\_\_\_  
Comments \_\_\_\_\_

9. Location (put one check if pain is typically mild. Put four checks if pain is typically  
severe. Check as many as apply)

Sidedness:  
Mainly on the right \_\_\_ Mainly on the left \_\_\_ Often on both sides \_\_\_  
Side varies from attack to attack \_\_\_ Side changes during attack \_\_\_

Location (Put one check or one x if pain typically mild at this location. Put four checks  
or x's if pain is often severe at this location.

Right Temple (side toward front) ) \_\_\_ Left Temple \_\_\_  
Back of Head (occipital) \_\_\_ Back of neck \_\_\_ Ear \_\_\_ Jaw \_\_\_ Nose \_\_\_  
Right side of neck \_\_\_ Left side of neck \_\_\_ Front of neck \_\_\_  
Right side toward middle of head (parietal) \_\_\_ Left side toward middle of head

\_\_\_\_\_  
Top of head \_\_\_ In a circle around the head \_\_\_  
In or behind Right Eye \_\_\_ In or behind Left Eye \_\_\_  
Above the Eye (front temple) \_\_\_ Below the Eye (cheek bone) \_\_\_  
All over the head \_\_\_ Comments \_\_\_\_\_

**For your Second Most Important Headache (cont.)**

10. Characteristics (check as many as apply):

Throbbing/ pulsing \_\_\_\_\_ Pressure \_\_\_\_\_  
Achy \_\_\_\_\_ Burning \_\_\_\_\_  
Tight \_\_\_\_\_ Searing \_\_\_\_\_  
Dull \_\_\_\_\_ Shooting \_\_\_\_\_  
Stabbing \_\_\_\_\_ Other \_\_\_\_\_

Comments: \_\_\_\_\_

11. Activity That Bring On or Worsen Headache (Place one check or x for factors that mildly or only occasionally bring on or worsen headache. Place four checks or x's for factors that often or severely bring on or worsen headache.)

None \_\_\_\_\_ Walking \_\_\_\_\_ Climbing Steps \_\_\_\_\_ Exercise \_\_\_\_\_  
Coughing \_\_\_\_\_ Talking \_\_\_\_\_ Clenching, chewing or moving Jaw \_\_\_\_\_ Turning  
Head/Neck \_\_\_\_\_ Sleep (lack of) \_\_\_\_\_ Sleep (too much) \_\_\_\_\_ Sleep (disturbed)  
Sexual Activity \_\_\_\_\_ Skipping Meals \_\_\_\_\_ Eating particular foods \_\_\_\_\_  
Computer \_\_\_\_\_ Period or PMS \_\_\_\_\_ Pregnancy \_\_\_\_\_ Menopause \_\_\_\_\_  
Emotional Distress \_\_\_\_\_ (work \_\_\_\_\_ home \_\_\_\_\_ family \_\_\_\_\_ spouse \_\_\_\_\_ Other \_\_\_\_\_  
Alcohol \_\_\_\_\_ Too much caffeine \_\_\_\_\_ Not enough caffeine \_\_\_\_\_ Tobacco \_\_\_\_\_  
Any Medicines \_\_\_\_\_ which? \_\_\_\_\_  
Bright lights \_\_\_\_\_ Loud Noises \_\_\_\_\_ Smells/odors \_\_\_\_\_  
Allergies \_\_\_\_\_ Weather changes \_\_\_\_\_ altitude \_\_\_\_\_, sunlight \_\_\_\_\_

Other triggers/Comments: \_\_\_\_\_

12. Headache Disability During or After an Attack

Normal activity \_\_\_\_\_ Slight decrease in function \_\_\_\_\_ Moderate decrease \_\_\_\_\_  
Severe decrease in function \_\_\_\_\_ Confined to bed \_\_\_\_\_

13. Associated Symptoms

Nausea \_\_\_\_\_ Vomiting \_\_\_\_\_ Sensitivity to Light \_\_\_\_\_ Sensitivity to Sounds \_\_\_\_\_  
Sensitivity to Odors \_\_\_\_\_  
Diarrhea \_\_\_\_\_ Constipation \_\_\_\_\_ Insomnia \_\_\_\_\_ Increased Urination \_\_\_\_\_  
Sore/stiff neck \_\_\_\_\_ Ringing in ears \_\_\_\_\_ Anxiety/Irritability \_\_\_\_\_ Depression \_\_\_\_\_  
Concentration Problems \_\_\_\_\_ Memory Problems \_\_\_\_\_ Confusion \_\_\_\_\_  
Increased appetite \_\_\_\_\_ Decreased appetite \_\_\_\_\_  
Eye Tearing (Rt \_\_\_\_\_ Left \_\_\_\_\_ both \_\_\_\_\_) Drooping Eyelid (Rt \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_)  
Change in Pupil (larger \_\_\_\_\_ smaller \_\_\_\_\_)

Comments: \_\_\_\_\_

**For your Second Most Important Headache (cont.)**

14. Aura: Visual (Do you often \_\_\_\_ ever \_\_\_\_ have these symptoms before your headache begins?)

Blurry vision \_\_\_\_ Tunnel vision \_\_\_\_  
 Flashing lights \_\_\_\_ Double vision \_\_\_\_  
 Zigzag lines \_\_\_\_  
 Loss of vision in one eye \_\_\_\_ loss of vision on one side \_\_\_\_ total blindness \_\_\_\_

Aura Sensory: (Do you often \_\_\_\_ ever \_\_\_\_ have these symptoms before your headache begins?)

Numbness/tingling right \_\_\_\_ Numbness/tingling left \_\_\_\_  
 Dizziness/unsteadiness \_\_\_\_ Vertigo (spinning) \_\_\_\_ Light headedness \_\_\_\_  
 Weakness on one side \_\_\_\_ General weakness \_\_\_\_ speech difficulty \_\_\_\_  
 Other \_\_\_\_\_

Does your aura spread? Yes, spreads slowly \_\_\_\_ No, begins all at once \_\_\_\_

15. Premonitory Symptoms (Do you experience one or more of these before onset of headache)

Increased feeling of wellness ____	Difficulty Concentrating ____
Hyperactive ____	Sensitive to light ____
Talkative ____	Sensitive to noise ____
Depressed feeling ____	Sensitive to odors ____
Irritable ____	Difficulty with speech ____
Sluggish ____	Yawning ____
Drowsy ____	Neck stiff ____
Restless ____	Food cravings ____
Dizzy ____	weakness ____
Light headed ____	Feeling cold ____
Diarrhea ____	Increased appetite ____
Constipation ____	Decreased appetite ____
Extremely thirsty ____	Other _____
Increased urination ____	_____
Fluid retention ____	_____

## For your Second Most Important Headache (cont.)

### 16. Relieving Factors:

Lying down \_\_\_\_\_ Dark/quiet room \_\_\_\_\_ Lying down \_\_\_\_\_ Pregnancy \_\_\_\_\_  
Hot compress \_\_\_\_\_ Cold compress \_\_\_\_\_ Sleep \_\_\_\_\_  
Keeping active \_\_\_\_\_ Standing \_\_\_\_\_ Massage \_\_\_\_\_  
Physical position \_\_\_\_\_

Medicines: Aspirin \_\_\_ Advil/Ibuprofen \_\_\_\_\_ Tylenol/acetaminophen \_\_\_\_\_  
Triptans (e.g. Imitrex) \_\_\_\_\_ If yes, which works best?  
Ultram \_\_\_\_\_ Codeine \_\_\_\_\_ Other narcotic pain meds \_\_\_\_\_  
Muscle relaxants/ tranquilizers e.g. Valium, e.g. Flexeril e.g. Skelaxin ) \_\_\_\_\_  
Other medicines \_\_\_\_\_

Other/Comments: \_\_\_\_\_

\_\_\_\_\_

If you have a third or fourth type of headache distinct from the top two, please describe them here.

\_\_\_\_\_

\_\_\_\_\_

## Treatments You Have Tried That Might Be Relevant for Headache

**Please Circle any that you have taken or done.** If it did not help your headache leave the line to the right of the name blank. If it did help insert one to four checks or XX's. One checks or xx's=helped mildly; four checks or XX's=it helped a lot.

### Nutritional and Herbal

Butterbur(Patasites) \_\_\_\_\_  
Carnitine \_\_\_\_\_  
Coenzyme Q \_\_\_\_\_  
Feverfew \_\_\_\_\_  
Magnesium \_\_\_\_\_  
Melatonin \_\_\_\_\_  
Riboflavin(vit B2) \_\_\_\_\_  
Vitamin B12 \_\_\_\_\_  
Other \_\_\_\_\_

### Diet

Alcohol elimination \_\_\_\_\_ Gluten elimination \_\_\_\_\_  
Food additives \_\_\_\_\_ Hypoglycemia/low sugar \_\_\_\_\_  
Artificial sweeteners \_\_\_\_\_ Low salt \_\_\_\_\_  
Caffeine elimination \_\_\_\_\_ Milk elimination \_\_\_\_\_  
Candida yeast treatment \_\_\_\_\_ MSG \_\_\_\_\_  
Food allergy \_\_\_\_\_ Other \_\_\_\_\_

## Physical Modalities

Acupuncture \_\_\_\_  
Bath \_\_\_\_  
BoTox \_\_\_\_  
Chiropractic \_\_\_\_  
Craniosacral \_\_\_\_  
Dental Bite Plate for jaw (TMJ) \_\_\_\_  
Heat \_\_\_\_  
Ice/cold \_\_\_\_  
Lidocaine injctns \_\_\_\_  
Massage \_\_\_\_  
Nerve block injctns \_\_\_\_  
Nerve Stimulator \_\_\_\_  
Myofacial Release \_\_\_\_  
Physical therapy \_\_\_\_  
Pool/Aquatherapy \_\_\_\_  
Rolfing \_\_\_\_  
SAdMe (S-Adenosyl Methionine) \_\_\_\_  
TENS unit \_\_\_\_  
Trigger Point injctns \_\_\_\_  
Ultrasound \_\_\_\_  
Other \_\_\_\_\_

## Stress/Sleep/Behavioral

Biofeedback \_\_\_\_  
Deep Breathing \_\_\_\_  
Exercise \_\_\_\_  
Hypnosis \_\_\_\_  
Meditation \_\_\_\_  
Prayer \_\_\_\_  
Relaxation Skills \_\_\_\_  
Stress management \_\_\_\_  
Talk psychotherapy \_\_\_\_  
Sleeping Better \_\_\_\_  
Sleep Meds \_\_\_\_  
Yoga \_\_\_\_  
Other \_\_\_\_\_

## Medicines

### Anti-anxiety Meds:

Abilify \_\_\_\_  
Ativan (lorazepam) \_\_\_\_  
Buspar (buspirone) \_\_\_\_  
Chlorpromazine (Thorazine) \_\_\_\_  
Klonopin (clonazepam) \_\_\_\_  
Librium \_\_\_\_  
Risperdal \_\_\_\_  
Seroquel \_\_\_\_  
Valium (diazepam) \_\_\_\_  
Zyprexa \_\_\_\_

### Depression Related Meds:

Amitryptiline (Elavil) \_\_\_\_  
Celexa \_\_\_\_  
Cymbalta \_\_\_\_  
Doxepin (Sinequan) \_\_\_\_  
Effexor(venlafaxine) \_\_\_\_  
Lithium \_\_\_\_  
Lexapro \_\_\_\_  
Luvox \_\_\_\_  
Pamelor(nortriptyline)\_\_\_\_  
Paxil (paroxetene) \_\_\_\_  
Prozac (fluoxetine) \_\_\_\_  
Remeron(mirtazapine)\_\_\_\_  
Savella (minalcipram)\_\_\_\_  
Wellbutrin \_\_\_\_  
Xanax (alprazolam) \_\_\_\_  
Zoloft \_\_\_\_

### Beta blockers:

Corgard (nadolol) \_\_\_\_  
Inderal (propranolol)\_\_\_\_  
Lopressor(metoprolol)\_\_\_\_  
Toprol (Metoprolol ) \_\_\_\_  
Timolol (Blocadren) \_\_\_\_  
Tenormin(atenelol) \_\_\_\_

### Calcium Channel Blockers:

Diltiazem(Cardizem)\_\_\_\_  
Norvasc(amlodipine)\_\_\_\_  
Nifedepine(Procardia) \_\_\_\_  
Nimodipine (Nimotop)\_\_\_\_  
Verapamil (Calan) \_\_\_\_

**Medicines (cont.)**

**Anti-seizure/Migraine Preventive Medicines:**

Depakote (valproic acid/divalproex) \_\_\_\_

Lamictal (lamotrigine) \_\_\_\_

Lyrica (pregabalin) \_\_\_\_

Neurontin (gabapentin) \_\_\_\_

Tegretol (carbamazepine) \_\_\_\_

Topiramate (Topamax) \_\_\_\_

Trileptal (oxcarbazepine) \_\_\_\_

Zonergan \_\_\_\_

Other \_\_\_\_\_

**Muscle Relaxant Medicines:**

Baclofen \_\_\_\_

Parafon forte \_\_\_\_

Robaxin \_\_\_\_

Skelaxin \_\_\_\_

Soma \_\_\_\_

Valium (diazepam) \_\_\_\_

Xanax (alprazolam) \_\_\_\_

Zanaflex (tizanidine) \_\_\_\_

Other \_\_\_\_\_

**Antihistamines:**

Atarax(hydroxyzine) \_\_\_\_

Benadryl \_\_\_\_

Periactin/Cyproheptadine \_\_\_\_

Vistaril \_\_\_\_

Other \_\_\_\_\_

**Triptan Acute Migraine Relief Medicines:**

Amerge (naratriptan) \_\_\_\_

Axert (almotriptan) \_\_\_\_

Frova (frovatriptan) \_\_\_\_

Imitrex (sumatriptan) \_\_\_\_

Maxalt (rizatriptan) \_\_\_\_

Relpax (elitriptan) \_\_\_\_

Zomig (zolmitriptan) \_\_\_\_

Other \_\_\_\_\_

**Ergotamine Medicines:**

Cafergot \_\_\_\_

DHE (dihydroergotamine) nasal or IV \_\_\_\_

Other \_\_\_\_\_

**Anti-Inflammatory Pain Relief Medicines:**

Aspirin \_\_\_\_

**Medicines (cont.)**

**NSAIDS (non-steroidal anti-inflammatory meds):**

- Advil (ibuprofen) \_\_\_\_
- Celebrex \_\_\_\_
- Etodolac (Lodine) \_\_\_\_
- Fenoprofen (Nalfon) \_\_\_\_
- Flurbiprofen (Ansaid) \_\_\_\_
- Ibuprofen (Advil) \_\_\_\_
- Indocin (indomethacin) \_\_\_\_
- Ketoprofen (Orudis) \_\_\_\_
- Meclofenamic acid \_\_\_\_
- Mefenamic acid (Ponstel) \_\_\_\_
- Meloxicam (Mobic) \_\_\_\_
- Naproxen (Anaprox) \_\_\_\_
- Piroxicam (Feldene) \_\_\_\_
- Oxaprozin (Daypro) \_\_\_\_
- Sulindac (Clinoril) \_\_\_\_
- Toradol (etrolac) \_\_\_\_
- Voltaren(diclofenac) \_\_\_\_

**Corticosteroid:**

- Cortisol (cortisone) \_\_\_\_
- Decadron (dexamethasone) \_\_\_\_
- Medrol \_\_\_\_
- Prednisone \_\_\_\_

**Non-anti-inflammatory pain relief medicines:**

- Acetaminophen (Tylenol) \_\_\_\_
- Darvon \_\_\_\_
- Fiorenol/Fiorecet \_\_\_\_
- Lidocaine/Lidoderm patch \_\_\_\_
- Tylenol (acetaminophen) \_\_\_\_
- Ultram (tramadol) \_\_\_\_

**Other Acute Treatment Headache Medicines:**

- Compazine \_\_\_\_
- Lidocaine IV (or as patch) \_\_\_\_
- Fluids IV \_\_\_\_
- Ketamine IV (or oral) \_\_\_\_
- Magnesium IV \_\_\_\_
- Methysergide(Sansert) \_\_\_\_
- Midrin (isomethptine) \_\_\_\_
- Reglan (metoclopramide) \_\_\_\_
- Tigan \_\_\_\_
- Zofran \_\_\_\_
- Other \_\_\_\_\_

**Medicines (cont.)**

**Opioids pain medicines (narcotics):**

- Codeine \_\_\_\_
- Dilaudid (hydromorphone) \_\_\_\_
- Fentanyl patch (Duragesic) \_\_\_\_
- Oxycodone (e.g. Percocet) \_\_\_\_
- Oxycontin(long acting oxycodone) \_\_\_\_
- Morphine regular release \_\_\_\_
- Morphine slow release (e.g. MS Contin) \_\_\_\_
- Methadone \_\_\_\_
- Naltrexone (low dose) \_\_\_\_
- Percodan/Percocet (oxycodone) \_\_\_\_
- Vicodin (hydrocodone) \_\_\_\_

**YOUR CURRENT MEDICINES**

**(Please do not forget birth control pills and over the counter medicines)**

MEDICINE	Purpose	Dose	Times per Day	Side-effects

**Current Nutritional and Herbal Supplements**  
 (check or mark x by those you take)

Name/Type of Supplement	# pills or mgs or units daily if known
Multivitamin ____	_____
Fish Oil ____	_____
Flax Oil ____	_____
Other oils ____	_____
Vitamin D ____	_____
Calcium ____	_____
Magnesium ____	_____
Multi B ____	_____
N-Acetyl Cysteine(NAC)____	_____
Iron ____	_____
Coenzyme Q ____	_____
Carnitine ____	_____
St. John's Wort ____	_____
Ribflavin (B2) ____	_____
Melatonin ____	_____
Other vitamin/mineral or herbal products ____	_____

**Family History**

Is there a Personal (P) or Family history (F) of: MIGRAINE, other headaches?

---

Is there a Personal or family history of cancer? (specify)

---

Is there a personal history of high blood pressure\_\_\_\_, high cholesterol\_\_\_\_  
 Serious overweight \_\_\_\_ cigarette smoking \_\_\_\_

Is there a personal or family history of heart attack, serious heart rhythm abnormality, stroke, aortic aneurysm, or peripheral vascular disease occurring before age 65?

---

Is there a personal or family history of autoimmune diseases such as rheumatoid arthritis, Lupus, Crohn's disease, ulcerative colitis, spinal arthritis, Sjogren's syndrome (dry eyes, mouth)? \_\_\_\_\_

Is there a personal or family history of thyroid disorders? \_\_\_\_\_

**NEUROCHEMICAL**

Do you have a family history of: Major Depression\_\_\_\_ Manic Depressive Illness\_\_\_\_  
 Major Anxiety\_\_\_\_ Panic Anxiety\_\_\_\_ Alcoholism or Drug Abuse\_\_\_\_ Suicide Attempt or  
 Success\_\_\_\_ Attention Deficit\_\_\_\_ Obsessive-Compulsive Disorder\_\_\_\_  
 Schizophrenia\_\_\_\_\_

## Review of Systems:

### EXERCISE

I can comfortably walk:

<1/4 Mile \_\_\_\_\_ 1/4 Mile \_\_\_\_\_ 1/2 Mile \_\_\_\_\_ 1 Mile \_\_\_\_\_ >1 Mile \_\_\_\_\_

If you cannot comfortably walk one mile what are the main limiting factor(s)? Weakness \_\_\_\_\_

Short of breath \_\_\_\_\_ Joint pain \_\_\_\_\_ Muscle pain \_\_\_\_\_

Chest pressure or pain \_\_\_\_\_ Rapid heart \_\_\_\_\_

Haven't tried to exercise much, so I'm not sure \_\_\_\_\_

Comment \_\_\_\_\_

During the last few months I have typically exercised: \_\_\_\_\_ times a week for

about \_\_\_\_\_ minutes at a time. Intensity: Gentle \_\_\_\_\_ Moderate \_\_\_\_\_ Vigorous \_\_\_\_\_

Usual type of exercise \_\_\_\_\_ If you don't exercise, state why \_\_\_\_\_

For current exercise my preferred form would be: Walking \_\_\_\_\_ Treadmill \_\_\_\_\_

Swimming \_\_\_\_\_ Indoor Bike \_\_\_\_\_ Other \_\_\_\_\_

When I exercise I usually feel: better \_\_\_\_\_ the same \_\_\_\_\_ immediately worse but recover quickly \_\_\_\_\_ immediately worse but take many hours to recover \_\_\_\_\_ immediately not bad but get worse hours later or the next day \_\_\_\_\_ not sure \_\_\_\_\_

### SLEEP

Usual hour to bed \_\_\_\_\_ Usual length of time it takes to fall asleep \_\_\_\_\_

Is initially falling asleep often a problem? \_\_\_\_\_

Is staying asleep during the night often a problem? \_\_\_\_\_

About what time do you get up in the morning? \_\_\_\_\_

Subtracting interruptions, about how many hours do you actually sleep? \_\_\_\_\_

Do you usually need an alarm clock to wake you up? \_\_\_\_\_

Do you usually sleep more than 45 minutes longer on weekends or holidays? \_\_\_\_\_

When you wake in the morning do you usually feel you have rested well? \_\_\_\_\_

Do you take naps? \_\_\_\_\_ Do these refresh you? ` \_\_\_\_\_

Are you sleeping much less (say 45 minutes or more less) than you used to when you were last feeling well? \_\_\_\_\_

Do you ever fall asleep inappropriately, e.g. at work/school \_\_\_\_\_ While driving \_\_\_\_\_

With other people \_\_\_\_\_ Watching TV \_\_\_\_\_

Do you or did you take sleeping aides more than once a week? \_\_\_\_\_ If yes, please state the name(s) and whether they Helped (H), made No Change (NC) or made you Worse (W): \_\_\_\_\_

SLEEP OBSERVATION: Is there someone who could observe you while you are asleep for 30 minutes. If yes, please ask that person to observe your breathing while you are asleep.

Is snoring rare? \_\_\_\_\_, Mild \_\_\_\_\_, Moderate \_\_\_\_\_, Severe \_\_\_\_\_?

Does breathing often stop for 10 seconds or longer? \_\_\_\_\_ Is there difficulty breathing, snorting or struggling for breath? \_\_\_\_\_

Is there often muscle twitching or jerking during sleep? \_\_\_\_\_ Do you toss and turn alot? \_\_\_\_\_ Do you sleep quietly, hardly moving at all? \_\_\_\_\_

Do you often wake with a headache? \_\_\_\_\_ Muscle aches? \_\_\_\_\_

## NUTRITION/GASTROINTESTINAL/FOOD ALLERGY

### DIET

How do you rate your diet: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Comments: \_\_\_\_\_

About how many times in an average week do you eat: Green leafy vegetables (excluding lettuce) \_\_\_\_\_ Yellow vegetables (carrot/squash/sweet potato) \_\_\_\_\_ Berries \_\_\_\_\_

Fruit \_\_\_\_\_ Fish \_\_\_\_\_ Yogurt \_\_\_\_\_ Milk/cheese \_\_\_\_\_

Ice cream \_\_\_\_\_ Chocolate \_\_\_\_\_ Beef/pork \_\_\_\_\_ Chicken/turkey \_\_\_\_\_

Salad dressing or vegetable oil \_\_\_\_\_ Soy \_\_\_\_\_ Nuts/beans/seeds \_\_\_\_\_

How many times a week do you: Eat at home \_\_\_\_\_ In a restaurant \_\_\_\_\_

Skip breakfast \_\_\_\_\_ Skip lunch \_\_\_\_\_ Skip dinner \_\_\_\_\_

Do you consciously try to reduce your intake of: Sugars \_\_\_\_\_ Other carbohydrates \_\_\_\_\_

Artificial sweeteners \_\_\_\_\_ Caffeine \_\_\_\_\_ Alcohol \_\_\_\_\_ Protein \_\_\_\_\_

Why? \_\_\_\_\_

Do you restrict your fat intake: Mildly \_\_\_\_\_ Severely \_\_\_\_\_ Not at all \_\_\_\_\_

Do the following foods often help you feel Better (B) or Worse (W)? Sugar \_\_\_\_\_ Starch \_\_\_\_\_

Alcohol \_\_\_\_\_ Caffeine \_\_\_\_\_ Milk products \_\_\_\_\_ Fatty foods \_\_\_\_\_ Organic food \_\_\_\_\_

Yeast/mold \_\_\_\_\_ Additives \_\_\_\_\_ Wheat/gluten \_\_\_\_\_ Chocolate \_\_\_\_\_ Garlic/onion \_\_\_\_\_

Spices \_\_\_\_\_ Deli meats \_\_\_\_\_ MSG \_\_\_\_\_ Artificial sweeteners \_\_\_\_\_

Are there specific foods you feel you "almost can't live without?" If so, which? \_\_\_\_\_ Do you avoid certain foods because you suspect you are allergic or do not tolerate them? Which? \_\_\_\_\_

### CAFFEINE

How many cups/glasses per day do you drink of: Coffee \_\_\_\_\_

Decaff coffee \_\_\_\_\_ Tea \_\_\_\_\_ Herbal tea \_\_\_\_\_ Cola drinks \_\_\_\_\_

Other soft drinks \_\_\_\_\_

If you drink caffeinated drinks regularly, have you abstained completely from caffeine for two days or more since you have been ill? \_\_\_\_\_ If so, what happened? \_\_\_\_\_

If you omitted caffeine, do you think you would likely develop a headache \_\_\_\_\_ Muscle ache \_\_\_\_\_ Severe fatigue \_\_\_\_\_ Mental cloudiness \_\_\_\_\_?

Don't know, I haven't tried? \_\_\_\_\_

### ALCOHOL

Indicate how many portions a day you typically have: Whiskey \_\_\_\_\_ Wine \_\_\_\_\_ Beer \_\_\_\_\_

Other alcohol \_\_\_\_\_

Do you or anyone else suspect you might have a drinking problem? \_\_\_\_\_

### HYPOGLYCEMIA

Do you suspect you might have "Hypoglycemia?" \_\_\_\_\_ Do you often have increased symptoms 3 or 4 hours after eating? \_\_\_\_\_ Or if your meal is late? \_\_\_\_\_ Or if you eat too much sugar or starch? \_\_\_\_\_ What are your symptoms? \_\_\_\_\_

Do you have increased symptoms within one hour of eating? \_\_\_\_\_ Which symptoms? \_\_\_\_\_

Do you usually have snacks? \_\_\_\_\_ When? \_\_\_\_\_ Is snacking helpful? \_\_\_\_\_

**CANDIDA (YEAST) SYNDROME** (controversial and unproved)

Do you often have vaginal yeast infections? \_\_\_\_\_ Do you often have intestinal gas, bloating, diarrhea or constipation? \_\_\_\_\_ Do your symptoms worsen when you eat a high sugar or high carbohydrate diet? \_\_\_\_\_ Do they improve with reducing sugar, bread, and/or starch? \_\_\_\_\_ Do symptoms worsen with alcohol? \_\_\_\_\_ Have you or a health care professional suspected that you have a yeast or Candida problem? \_\_\_\_\_ If so, when, by whom and what test? \_\_\_\_\_ Have you tried at least two months of a Candida yeast diet with or without medicines or supplements? \_\_\_\_\_ Did it help \_\_\_\_\_ Cause no change \_\_\_\_\_ Make you worse \_\_\_\_\_

**OTHER G.I.**

Do you often have diarrhea (multiple or loose stools) \_\_\_\_\_ Constipation \_\_\_\_\_ Abdominal gas or bloating \_\_\_\_\_? Do you ever have blood in your stool \_\_\_\_\_ Very dark tarry stool \_\_\_\_\_? What factors do you suspect of contributing to these symptoms? \_\_\_\_\_ Do you often take extra fiber or fiber pills \_\_\_\_\_ Stool softeners \_\_\_\_\_ Laxatives \_\_\_\_\_? If yes, do they usually seem to help \_\_\_\_\_ Cause no change \_\_\_\_\_ Make you worse \_\_\_\_\_? Do you often have excess acid symptoms, gastritis, esophagitis, heartburn, or esophageal reflux? \_\_\_\_\_ Have you ever been tested for Helicobacter bacteria (H. Pylorus)? \_\_\_\_\_ Was the test positive? \_\_\_\_\_ Were you treated? \_\_\_\_\_ Have you ever had intestinal parasites, worms, ameba, giardia or other intestinal infection? \_\_\_\_\_

**HIDDEN INFECTIONS AND ALLERGIES**

**Nose/Sinus**

Have you had a sinus infection in the last 4 months or more than 2 sinus infections in the last year? \_\_\_\_\_ Do you have chronic nasal stuffiness? \_\_\_\_\_ Post nasal drip \_\_\_\_\_ Hoarse voice \_\_\_\_\_? Do you often have yellow or green mucus from your nose, lungs or throat? \_\_\_\_\_ Do you often have sinus-type pressure over, under or between your eyes? \_\_\_\_\_ Do you have frequent sore throats \_\_\_\_\_ Have you ever had a sinus CT scan or x-ray? \_\_\_\_\_ Results? \_\_\_\_\_ Do you seem to react with allergies? \_\_\_\_\_ What kind? \_\_\_\_\_ Are you exposed to high doses of unusual chemicals as well as indoor or outdoor air pollutants? \_\_\_\_\_ Is your work or home environment poorly ventilated? \_\_\_\_\_ Is it exceptionally dry? \_\_\_\_\_ Humid? \_\_\_\_\_ Did any changes in your work or household environment precede the worsening of your health? \_\_\_\_\_ Do you develop symptoms when exposed to environmental chemicals or odors? \_\_\_\_\_

**Asthma/Bronchitis**

Is this a concern? \_\_\_\_\_ Do you often Wheeze \_\_\_\_\_ Cough \_\_\_\_\_ Feel chest tightness \_\_\_\_\_ Abnormal shortness of breath \_\_\_\_\_? Does exercise make it worse? \_\_\_\_\_ Does cold air? \_\_\_\_\_ Do you often cough mucus from your lungs? \_\_\_\_\_ Have you ever had a lung function test or been told you have Asthma, Emphysema or any other Lung Disease? \_\_\_\_\_ Have you had a Chest X-Ray within the last 5 years? \_\_\_\_\_ When? \_\_\_\_\_ Results? \_\_\_\_\_ Do you currently smoke tobacco? \_\_\_\_\_ Have you smoked regularly within the last 5 years? \_\_\_\_\_

**Urine/Prostate**

Do you often have burning or pain when you pass your urine? \_\_\_\_\_

Do you have difficulty starting urination? \_\_\_\_\_ Slow urine flow? \_\_\_\_\_

Do you ever spill urine accidentally (incontinence)? \_\_\_\_\_ Have you ever had kidney stones? \_\_\_\_\_ Do you have diabetes or a blood sugar problem? \_\_\_\_\_

Women: Do you have more than one urine infection per year? \_\_\_\_\_

Men: Have you ever had urine infections? \_\_\_\_\_

Comments: \_\_\_\_\_

**Lyme Disease:**

Have you ever had or been told that you had Lyme Disease? Yes \_\_\_ No \_\_\_ Not sure \_\_\_

Have you had a bull's eye type rash that grew over several weeks or months before disappearing? \_\_\_\_\_ Have you ever had an abrupt weakness on one or both sides of your face (Bell's Palsy)? \_\_\_\_\_

Are you often exposed to ticks? \_\_\_\_\_

Comments: \_\_\_\_\_

**Fever and Other Infections**

Do you often feel warm? \_\_\_\_\_ Have chills? \_\_\_\_\_ When you feel warm what is your actual temperature range? \_\_\_\_\_ Have you ever had hepatitis? \_\_\_\_\_

Do you have any AIDS risk factors or abnormal tests? \_\_\_\_\_

Have you had close exposure to someone with tuberculosis, a positive skin test or signs of T.B. on a chest x-ray? \_\_\_\_\_

**HORMONES****PMS/Menstrual**

Do important symptoms get markedly worse in the week or two before your period and improve substantially once you have had your period? \_\_\_\_\_ If yes, which symptoms? \_\_\_\_\_

Do you have menstrual cramps or related symptoms that are severe enough to disturb your feeling of well-being or daily function? \_\_\_\_\_ Do you have vaginal bleeding other than at your period? \_\_\_\_\_

Are you taking contraceptives or other measures to avoid pregnancy? \_\_\_\_\_

**Perimenopause**

Do you have mood swings \_\_\_\_\_ Hot flashes \_\_\_\_\_ Night sweats \_\_\_\_\_?

**Menopause**

Are hot flashes or night sweats very bothersome? \_\_\_\_\_ Have you had a hysterectomy? \_\_\_\_\_ Which symptoms, if any, improved or worsened after menopause? \_\_\_\_\_

## Thyroid

Have you ever been told that your thyroid is abnormal? \_\_\_\_\_ Ever on thyroid medicines? \_\_\_\_\_  
Do you have any swelling in the lower neck? \_\_\_\_\_ Did you ever receive x-ray treatments to  
the neck? \_\_\_\_\_ Family History of Thyroid disease? \_\_\_\_\_ Are you intolerant of cold? \_\_\_\_\_ Is  
your auxiliary temperature <97 degrees before you get out of bed? \_\_\_\_\_ Do you feel  
hyper? \_\_\_\_\_ Intolerant of heat? \_\_\_\_\_ Rapid heart rate? \_\_\_\_\_ Weight gain or loss? \_\_\_\_\_  
Sweats? \_\_\_\_\_ Anxiety? \_\_\_\_\_

## Other

Do you have any discharge from your nipples? \_\_\_\_\_ Has anyone told you that you have  
low adrenals? \_\_\_\_\_ Do you have excess hair growth on face or body? \_\_\_\_\_

## HEART/BLOOD PRESSURE

Do you often feel light-headed or have a rapid heart rate when you stand up quickly? \_\_\_\_\_  
When you stand still for awhile? \_\_\_\_\_ Orthostatic symptoms: Do you tend to have low blood  
pressure? \_\_\_\_\_ High blood pressure? \_\_\_\_\_  
Do you have chest tightness, pressure or pain, or any distress or abnormality when you exert  
yourself or exercise? \_\_\_\_\_ Have you ever had a heart attack or angina? \_\_\_\_\_ Heart  
catheterization? \_\_\_\_\_ Angioplasty or heart surgery? \_\_\_\_\_ Have you ever had a stroke or  
near-stroke (TIA)? \_\_\_\_\_ Do you often have calf or leg pain when you walk? \_\_\_\_\_  
Have you ever had an EKG? \_\_\_\_\_ Exercise Stress test? \_\_\_\_\_ ECHO cardiogram? \_\_\_\_\_  
Were any results abnormal? \_\_\_\_\_  
Do you have Mitral Valve Prolapse? \_\_\_\_\_ Other murmurs or heart valve problems? \_\_\_\_\_  
Frequent extra or skipped heart beats/palpitations? \_\_\_\_\_ Need antibiotics before seeing a  
dentist? \_\_\_\_\_

## NEUROCHEMICAL BALANCE & EMOTIONAL HEALTH

X if the question applies to you. Leave blank if it does not.

During the last three months have you been under severe emotional stress? Yes \_\_\_\_\_

No \_\_\_\_\_ Not sure \_\_\_\_\_ If yes, what do you think are the most important  
contributors? \_\_\_\_\_

Are you under the care of a therapist? Who and why? Is it helping?  
\_\_\_\_\_

Who are the individuals (and ages) that live with you?  
\_\_\_\_\_

What is the attitude of those closest to you regarding you and your illness?  
\_\_\_\_\_

Describe your attitude toward your illness. (mark along scale)

Hopeless/Pessimistic 0 \_\_\_\_\_ 10 Hopeful/Optimistic

## STRESS/ANXIETY

Has there been increased stress in your life? \_\_\_\_\_

Why? \_\_\_\_\_

Do you feel nervous, jittery or anxious more often than you  
like? \_\_\_\_\_ Why? \_\_\_\_\_

**Do you often have these symptoms? (Circle symptoms that apply):**

**Physical Muscle tension or activity:** Jumpiness, Trembling, Muscle-Tightness, Heaviness or Aching, Fidgeting, Restless, Easy to Startle

**Symptoms of over-activation:** Sweating, Heart-Pounding, Cold or Clammy Hands, Dry Mouth, Light-Headed, Numbness, Tingling, Hot or Cold Spells, Frequent Urination, Diarrhea, Stomach Discomfort, Lump in Throat, Flushing, Paleness, Breathless

**Fears:** Worry, Fearful expectations about self or family, Fear of losing control or having an accident, Specific phobias or fears such as: Being Alone, Open Spaces, Closed Spaces, Automobiles, Bridges, Heights

**Hyper alertness:** To threats or troubles in the environment, To symptoms or functions of your body, On-edge, Irritable, Impatient, Difficulty Sleeping

Have you ever had a "panic attack?" \_\_\_\_\_ Do you have them more than once a month? \_\_\_\_\_ Do you spend much time or energy anticipating or worrying about your next episode of symptoms or illness? \_\_\_\_\_

**DEPRESSION**

Do you often feel: Loss of enthusiasm or interest in your usual activities \_\_\_\_\_  
Depressed/sad/blue \_\_\_\_\_ Loss of appetite \_\_\_\_\_ Increased appetite \_\_\_\_\_ Weight loss \_\_\_\_\_  
Weight gain \_\_\_\_\_ Life seems not worth living \_\_\_\_\_ Have you ever seriously considered  
suicide? \_\_\_\_\_ Have you thought of suicide recently? \_\_\_\_\_

Explain: \_\_\_\_\_

Have there been important reverses in personal/family/finance? \_\_\_\_\_ Increased use  
of alcohol, drugs or caffeine \_\_\_\_\_ Increased use of mood altering medicines \_\_\_\_\_ Have you  
ever been seriously depressed \_\_\_\_\_ Have you taken medicines for depression? \_\_\_\_\_  
Which? \_\_\_\_\_ Did they  
help? \_\_\_\_\_

Is depression or fatigue usually worse in the winter and better in the spring or on vacations to  
warm climates? \_\_\_\_\_

**MANIC/DEPRESSIVE (Bipolar) DISORDER**

Are there periods during which you are abnormally super-productive or  
manic? \_\_\_\_\_

Has anyone ever suggested that you might be "hypomanic" or have manic-depressive or  
bipolar depression? \_\_\_\_\_

**POST-TRAUMATIC STRESS**

Has there been major physical or emotional trauma any time in your life?

For example: Loss of a loved one \_\_\_\_\_ Divorce \_\_\_\_\_ Physical abuse/violence \_\_\_\_\_ Sexual  
abuse (e.g. rape or incest) \_\_\_\_\_ A serious accident or illness \_\_\_\_\_

Do disturbing thoughts, dreams, or images related to past events recur  
frequently? \_\_\_\_\_

**OBSESSIVE-COMPULSIVE TRAITS**

Do thoughts often intrude that you cannot keep out? \_\_\_\_\_ Do you feel compulsive impulses  
to perform hand-washing, counting, throat-clearing, touching or phrases, noises or other acts  
or actions? \_\_\_\_\_ Do you have recurring tics or twitches? \_\_\_\_\_

### **HYPERVENTILATION SYNDROME**

Often lightheaded or dizzy\_\_\_\_\_ Numbness/ tingling\_\_\_\_\_ Spasm or cramps of hands or forearms\_\_\_\_\_ Feel short of breath\_\_\_\_\_ Frequent sighing\_\_\_\_\_ A sense that you can't take a full breath in\_\_\_\_\_ Short of breath with mild exertion\_\_\_\_\_ Feel "spacey"\_\_\_\_\_

### **ATTENTION DEFICIT DISORDER**

Have you had since childhood or teenage years great difficulty focusing or concentrating?\_\_\_\_\_ Have you had an unusually short attention span?\_\_\_\_\_ Have you or others thought that you might be "hyperactive" or have Deficit Syndrome?\_\_\_\_\_ Have you ever been treated with or benefited from Ritalin, Dexedrine or stimulant medicines?\_\_\_\_\_

### **PAVLOVIAN CONDITIONING**

Did your problem begin or increase markedly after a major illness, stress or accident?\_\_\_\_\_ Do direct or indirect reminders of difficult or traumatic episodes or periods tend to trigger your symptoms?\_\_\_\_\_ Once your symptoms begin, do you become more frightened, upset or tend to panic?\_\_\_\_\_ Do you spend time or energy anticipating or worrying about your next episode of symptoms or illness?\_\_\_\_\_ Do you have a powerful or vividly imaginative mind or creativity in art, music, dance or literature?\_\_\_\_\_ Can you produce interesting or detailed fantasies, daydreams or changes of mood with thoughts or mental imagery?\_\_\_\_\_

### **THOUGHT DISORDERS**

Illogical thoughts\_\_\_\_\_ Hallucinations\_\_\_\_\_ History of psychosis or schizophrenia\_\_\_\_\_ Paranoid thoughts\_\_\_\_\_ Erratic or highly variable moods\_\_\_\_\_

### **TYPE "A" PERSONALITY TRAIT**

Do you usually feel impatient, rushed or time pressured?\_\_\_\_\_ Are you often hostile or angry?\_\_\_\_\_

### **ASSOCIATED WITH LOW SEROTONIN**

Craving for sugar, or starch\_\_\_\_\_ Depression worse in winter\_\_\_\_\_ PMS\_\_\_\_\_ Decreased sweating\_\_\_\_\_ Intolerant of heat\_\_\_\_\_ Low grade fever\_\_\_\_\_ Feel chronically stressed\_\_\_\_\_ Often depressed\_\_\_\_\_

Are you now or have you recently been in counseling or therapy?\_\_\_\_\_ If yes:

Name\_\_\_\_\_ Tel:\_\_\_\_\_

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

## REVIEW OF CURRENT SYMPTOMS

√ for Mild √√ for Moderate √√√ for Severe

### Constitutional:

Fatigue/Tires \_\_\_\_\_  
Weight Change \_\_\_\_\_  
Fever/Chills/Sweats \_\_\_\_\_  
Appetite Change \_\_\_\_\_  
Abnormal Thirst \_\_\_\_\_  
Difficulty Sleeping \_\_\_\_\_  
Light-Headed \_\_\_\_\_

### Ears:

Itching \_\_\_\_\_  
Hearing Problem \_\_\_\_\_  
Blocked Ears \_\_\_\_\_  
Ringing in Ears \_\_\_\_\_  
Sensitive to Sound \_\_\_\_\_  
Dizziness/Vertigo \_\_\_\_\_

### Mouth:

Sores/Fissures \_\_\_\_\_  
Herpes or Frequent \_\_\_\_\_  
Cold Sores \_\_\_\_\_  
Gum/Tooth Problems \_\_\_\_\_  
Tongue Problem \_\_\_\_\_

### Lymph Nodes:

Swollen/Tender \_\_\_\_\_

### Lungs/Heart:

Cough \_\_\_\_\_  
Wheezing \_\_\_\_\_  
Shortness of Breath \_\_\_\_\_  
Hyperventilation \_\_\_\_\_  
Phlegm/Mucus/Bronchitis \_\_\_\_\_  
Chest Pain or Exertion \_\_\_\_\_  
Other Chest Pain/Distress \_\_\_\_\_  
Palpitations/rapid or Slow \_\_\_\_\_  
Or Irregular Heart Rate/Rhythm \_\_\_\_\_  
Ankle Swelling \_\_\_\_\_  
Calf Pain on Exercise \_\_\_\_\_  
Sore Tender Legs \_\_\_\_\_  
High/low Blood Pressure \_\_\_\_\_

### Muscles/Joints

Feel Stiff \_\_\_\_\_  
Ache/Sore muscles \_\_\_\_\_  
Joint Pain \_\_\_\_\_  
Joint Swelling \_\_\_\_\_  
Back Problems \_\_\_\_\_

### Eyes:

vision \_\_\_\_\_  
tearing \_\_\_\_\_  
itching \_\_\_\_\_  
feels heavy \_\_\_\_\_

### NOSE:

stuffed/runny \_\_\_\_\_  
post nasal drip \_\_\_\_\_  
sore throat \_\_\_\_\_  
hoarse voice \_\_\_\_\_  
trouble swallowing \_\_\_\_\_

### SKIN:

itching \_\_\_\_\_  
hives \_\_\_\_\_  
flushing \_\_\_\_\_  
rashes \_\_\_\_\_  
acne \_\_\_\_\_  
new or changed moles \_\_\_\_\_  
nail/hair problem \_\_\_\_\_

### Gastrointestinal:

nausea \_\_\_\_\_  
heartburn \_\_\_\_\_  
bloating \_\_\_\_\_  
belching/gas \_\_\_\_\_  
diarrhea \_\_\_\_\_  
constipation \_\_\_\_\_  
cramps \_\_\_\_\_  
rectal pain/burning \_\_\_\_\_  
blood or black stool \_\_\_\_\_  
worms or parasites \_\_\_\_\_

### Thyroid:

mass or lump in neck \_\_\_\_\_  
cold or heat intolerance \_\_\_\_\_  
Hx of X-rays to neck \_\_\_\_\_  
Feel hyper or sluggish \_\_\_\_\_

**REVIEW OF CURRENT SYMPTOMS (cont.)**

√ for Mild √√ for Moderate √√√ for Severe

**G.U. & Hormonal (Female):**

- Severe Menstrual Cramps \_\_\_\_\_
- Severe Premenstrual Symptoms \_\_\_\_\_
- Menstrual Irregularity \_\_\_\_\_
- Herpes \_\_\_\_\_
- Frequent Vaginal Discharge \_\_\_\_\_
- Yeast or Candida Infection \_\_\_\_\_
- Painful or Difficult Urination \_\_\_\_\_
- Pressure/Urgency/Itching \_\_\_\_\_
- Vaginal Rash \_\_\_\_\_
- Sexual Problem \_\_\_\_\_

**G.U. (Male)**

- difficulty voiding \_\_\_\_\_
- prostate problem \_\_\_\_\_
- lump on testes \_\_\_\_\_
- herpes \_\_\_\_\_
- sexual problem \_\_\_\_\_
- urine symptoms \_\_\_\_\_

**Neuropsychiatric:**

- Depression/Apathy \_\_\_\_\_
- Hyperactive \_\_\_\_\_
- “Brain Fog”/Difficulty \_\_\_\_\_
- Concentrating \_\_\_\_\_
- thoughts \_\_\_\_\_
- Feel as if losing control \_\_\_\_\_
- Faints/Blackouts \_\_\_\_\_

- Anxiety/Irritable \_\_\_\_\_
- Learning disability \_\_\_\_\_
- Mood swings \_\_\_\_\_
- homicidal thoughts \_\_\_\_\_
- Numbness, Tingling \_\_\_\_\_
- Seizures/Convulsions \_\_\_\_\_

**DIAGNOSTIC TESTS**

**Please complete this form and attach test results/reports or bring them with you at your initial appointment.**

For normal mark (N), for abnormal mark (A), for not sure mark (?). If not done please leave blank. Estimate the year test was last done

**Basic Tests**

- CBC \_\_\_\_\_
- Thyroid \_\_\_\_\_
- Liver Tests \_\_\_\_\_
- Blood Sugar \_\_\_\_\_
- SMA-6=Kidney, Potassium \_\_\_\_\_
- Urinalysis \_\_\_\_\_
- P.S.A. (Men) \_\_\_\_\_
- Mammogram \_\_\_\_\_

**Inflammatory/Autoimmune**

- Sed Rate \_\_\_\_\_ CPK (Muscle Enzyme) \_\_\_\_\_ CRP \_\_\_\_\_
- Rheumatoid Factor \_\_\_\_\_ Antinuclear Ab (ANA) \_\_\_\_\_

**Infections**

- Lyme Test \_\_\_\_\_ HIV test \_\_\_\_\_ Hepatitis Test \_\_\_\_\_ T.B. Test \_\_\_\_\_
- Chest X-Ray \_\_\_\_\_ Sinus C.T. Scan Or MRI \_\_\_\_\_
- Mycoplasma \_\_\_\_\_ Chlamydia \_\_\_\_\_ HHV-6 \_\_\_\_\_ Epstein-Barr \_\_\_\_\_

**Heart/Lung**

- EKG \_\_\_\_\_ Echocardiogram \_\_\_\_\_ Exercise Stress Test \_\_\_\_\_ Lung function test \_\_\_\_\_
- Other \_\_\_\_\_

## DIAGNOSTIC TESTS (cont.)

### Endocrine

Glucose Tolerance Test/Hb A1C/Insulin level \_\_\_\_\_

Adrenal Cortisol \_\_\_\_\_ DHEAS \_\_\_\_\_ Testosterone \_\_\_\_\_

Progesterone \_\_\_\_\_ Estrogen \_\_\_\_\_ Prolactin \_\_\_\_\_ Growth Hormone \_\_\_\_\_

### G.I.

Upper G.I. X-Ray or endoscopy \_\_\_\_\_

Colonoscopy \_\_\_\_\_ Sigmoidoscopy \_\_\_\_\_

Small Bowel X-Ray or capsule study \_\_\_\_\_

Helicobacter (H. Pylorus) test \_\_\_\_\_ Gluten test \_\_\_\_\_

Stool Test for Blood \_\_\_\_\_

### Neurology/Psychology

C.T. Brain \_\_\_\_\_ MRI of Brain \_\_\_\_\_

C.T. Cervical Spine \_\_\_\_\_ C.T. Thoracic Spine \_\_\_\_\_ C.T. Lumbar Spine \_\_\_\_\_

Neurology Consultant \_\_\_\_\_ Psychological Consult \_\_\_\_\_ EEG \_\_\_\_\_

Sleep Observation (At Home) \_\_\_\_\_ Sleep Observation (In Sleep Lab) \_\_\_\_\_