

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.

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
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:*

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/Fioretet _____
- 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) _____