

Dear New Patient:

Welcome. Enclosed is the New Patient General History Questionnaire you have requested. Please fill out the Questionnaire 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 process. 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. The initial evaluation and treatment phase typically consists of a comprehensive initial visit and then two to 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 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

Richard N. Podell, MD, MPH
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PATIENT HEALTH HISTORY QUESTIONNAIRE

Your Name _____ Date _____

DOB: _____ Social Security #: _____

Tel: _____ Fax: _____ E-mail: _____

Address: _____

City: _____ State: _____ Zip: _____

How Did You Hear Of Us?

Doctor Radio Newspaper 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?

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

4) Please comment on your most important current problems.

For the severity column, use **10 as severe and 0 as okay**. Rate as many as are important, especially if their severity score is 5 or more.

PROBLEM	SEVERITY (0-10) If very mild problem leave blank	ABOUT when did this first become a problem?	MARK if substantially worse in last year	MARK if worse in recent months
FATIGUE, poor exercise tolerance				
FATIGUE, decent exercise tolerance				
FATIGUE, not sure about exercise tolerance				
MUSCLE ACHES/ FIBROMYALGIA				
JOINT PAIN Without joint swelling				
JOINT PAIN With joint swelling				
HEAD/NECK PAIN				
SLEEP PROBLEMS				
DEPRESSION (Loss of enthusiasm)				
ANXIETY/STRESS				
CONCENTRATION/ MEMORY PROBLEMS				
WEIGHT GAIN				
WEIGHT LOSS				
DIZZINESS OR LOW BLOOD PRESSURE				
Heartburn, ulcer, irritable bowel, gas, constipation, diarrhea				
Sinus, nasal or allergy problems				
Food allergy or Intolerance				
Yeast (Candida) problem				
Nutritional Problem Specify: _____				
Fever				
Enlarged lymph glands				
Others: _____				

5) Describe the time and circumstances when the main problem(s) first appeared and/or worsened. (Feel free to type or write extended answers on a separate page.)

6) Are you currently working or in school?
What do you do?

7) Do your symptoms limit your effectiveness?

8) Current Medicines (include non-prescription and hormones)

Current Vitamins/Herbs

9) Medicine Allergies

10) Medicines Not Tolerated

11) Are you concerned about possible side-affects from any of your medicines?

12) Did any of your important symptoms worsen within a few weeks of starting or changing the dose of a medicine?

13) Have you recently used marijuana, cocaine, LSD or other street drugs?

Have you ever had a substance or alcohol problem?

14) State as specifically as you can which problem or kind of help you most want to focus on now AND what you would like to achieve through our consultations:

Do you have specific approaches or treatments in mind that you think might be helpful or that you want to be especially sure we consider? If so, please state:

15) If you have ever been hospitalized or had an operation indicate why and approximate dates:

16) Indicate how the following factors affect your major symptoms by marking (B) if they make you feel better, (W) worse, or (?) if you are not sure. If not relevant, leave blank. State which symptom(s) are affected.

Exercise _____ Sleep _____ Food/Eating _____ Alcohol _____
Caffeine _____ Salt _____ Stress _____ Season _____
Sunlight _____ Time of Day _____ Heat _____ Cold _____
Humidity _____ Barometric Pressure _____ Other _____

SECTION II: SPECIFIC SYMPTOM AREAS & LIFE-STYLE ISSUES

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

1) CHRONIC FATIGUE SYNDROME CRITERIA (Ann Int Med 1994;121:953-9)
New onset, persistent or relapsing, debilitating fatigue_____ No previous history of similar symptoms_____ Does not resolve rest_____ Persists at least 6 months_____ Substantial reduction of previous activity_____

Severe symptoms began: Suddenly_____ Gradually_____ Not sure_____

CHRONIC FATIGUE SYNDROME ADDITIONAL CRITERIA: "Official" diagnosis requires 4 or more of the following being present for more than six months:

- Impaired memory or concentration _____
- Frequent sore throat _____
- Painful/tender nodes esp. neck or armpit _____
- Muscle Pain (Myalgia) _____
 - With marked weakness _____
 - Without marked weakness _____
- Multi-joint pain _____
- (Without joint swelling or redness) _____
- New or different headaches _____
- Unrefreshing sleep _____
- Includes sleeping too much or too little _____

- Typically feel worse after physical activity _____

If so, when?

- Immediately after _____
- After several hours _____
- Both early and late _____
- Not sure _____
- Do not exercise _____

Other Potentially Related Symptoms

Light-headed, Faint, Dizzy, Vertigo, Off-Balance _____ Worse when standing _____
 Irritable Bowel: Gas _____ Constipation _____ Diarrhea _____ Blood in stool _____
 Anxiety _____ Panic _____ Breathless or disordered breathing _____ Alcohol
 problem in your history or in family _____ Vaginal discharge _____
 Comments: _____

2) MUSCLE ACHE/PAIN RELATED SYMPTOMS

Your age when muscle pain began _____ Onset was: Gradual _____ Sudden _____
 Describe: _____ Current status: Severe _____
 Moderate _____ Mild _____ Do joints swell _____ If yes,
 which? _____

Areas Involved (X for mild, XX for moderate, XXX for severe)

Head _____ Side(s) of head or temple(s) _____ Jaw _____ Neck _____ Right upper
 back _____ Left upper back _____ Right shoulder _____ Left shoulder _____
 Mid- back _____ Chest (worsens with exertion) _____ Chest (doesn't worsen with
 exertion) _____ Is pain worse when you breathe? _____ Low back/spine _____
 Right hip/buttock _____ Left hip/ buttock _____ Right upper leg _____
 Left upper leg _____ Does pain radiate down leg? _____ Right knee _____
 Left knee _____ Right calf _____ Left calf _____ Right foot/ankle _____
 Left foot/ankle _____ Right arm _____ Left arm _____ Right hand/wrist _____
 Left hand/wrist _____

Other areas of pain: _____

Are your muscles often very sore to the touch? _____
 If so, where, mainly? _____
 Does moderate exercise worsen pain? _____ Reduce pain? _____
 Have no effect? _____
 Is your pain much worse at night? _____
 Do you often feel stiff in the morning? _____
 Do you often have night sweats? _____
 Have you had x-rays of any of the painful areas? _____
 What did they show? _____

Is there a Personal (P) or Family history (F) of:

Psoriasis _____ Crohn's Disease or Ulcerative Colitis _____ Rheumatoid
 Arthritis _____ Spinal Arthritis _____ Ankylosing Spondylitis _____ Sjogren's
 Syndrome (dry eyes) _____

Which medicines help your muscle aches? X for a little, XX for moderate, XXX for very helpful, NC if No Change, W if it made you worse. Leave blank if you haven't tried it.

Aspirin or Ibuprofen _____ Celebrex or Vioxx (Cox-2 Anti-Inflammatories) _____
Tylenol _____ Codeine _____ Prednisone/Steroid _____ Percodan/Percoset _____
Ultram _____ Other _____

Have the following lab tests been abnormal? (leave blank if not done)

Sed Rate _____ CRP _____ Lyme Test _____ ANA _____ Rheumatoid Factor _____
Latex _____ CPK _____ HLA B-27 _____ SSA/SSO _____

3) FAMILY HISTORY

CIRCULATORY

Do you have a family history of:

Heart Attack, Stroke or Arterial Disease of the leg before age 60 _____
High Blood Pressure _____ High Cholesterol/Triglycerides _____ Diabetes _____

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 _____

CANCER

Do you have a family history of:

Breast Cancer _____ Colon or Rectal Cancer _____ Melanoma/Skin Cancer _____
Prostate Cancer _____ Stomach Cancer _____ Other _____

4) 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 _____

Exercise causes: abnormal chest pain or pressure _____, wheezing _____, mental cloudiness _____, other unusual symptoms _____.

5) SLEEP

INAPPROPRIATE SLEEP

About what time do you usually go to bed? _____
About what time do you usually actually fall asleep? _____
Is initially falling asleep often a problem? _____
Do you wake often during the night? _____
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 that 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? _____

6) 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_____ Moderately_____ 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?_____

Have you had food allergy testing? _____ What kind of test? _____ What were the results?_____ Are these results generally consistent with your experience?_____

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 often taken antibiotics?_____ Estrogen hormones or birth control pills?

_____ Cortisone/Prednisone? _____

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?_____

7) ENVIRONMENTAL HEALTH

FACTOR	DOES IT HURT YOU?
Noise	
Heat/humidity	
Lights	
Odors or Smells	
Computers	
Others being ill	
Tobacco/Indoor Pollution	
Occupational Chemicals	
Cold	
Repetitive Tasks	
Posture	

Comments:

How old is your home?_____ Is it often damp_____ Moldy_____ Dry_____ Very dusty_____ Pets_____? Do you have air-conditioning_____ Central A/C_____ Bedroom A/C_____? In your bedroom do you have: Carpets_____ Area carpet_____ Wall to wall carpet_____ A central air filter_____ Portable filters_____?

SECTION III: PHYSICAL ILLNESS

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

1) 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 you nose, lungs or throat?_____ Do you often have sinus-type pressure over, under or between your eyes?_____ Do you have a sore throat more than once every 8 weeks?_____ 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? _____ Is it Clear _____ Yellow _____
Green _____?

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? _____

2) 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?
Yes _____ No _____ Not sure _____

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?_____

3) 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?_____

About what level is your total cholesterol?_____ LDL?_____ HDL?_____ Triglycerides?_____ Homocysteine?_____

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?_____

4) HEADACHE

Do you have a headache more than once weekly?_____ Severe enough to reduce activity_____ On one side of head at a time_____ Preceded by "aura"_____ With nausea_____ (These suggest migraine) Related to: Stress_____ Posture/position_____ Nasal sinus congestion_____ Muscle tension_____ Medicines_____ Caffeine_____ Food_____ Do headaches wake you from sleep?_____ Worse on waking in AM_____ Pain in jaw_____ Grind teeth at night_____ Jaw locks or can't open widely_____ How often do you take headache medicine?_____ Do you drink caffeine or take pills with caffeine daily?_____

SECTION IV: 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

1) 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?

2) 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 ever
taken medicines for depression?____ Which ones?_____
Did they help?_____

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

3) 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?_____

4) 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?_____

5) 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?_____

6) 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"_____

7) 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 Attention

Deficit Syndrome?_____ Have you ever been treated with or benefited from Ritalin, Dexedrine or stimulant medicines?_____

8) 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?_____

9) THOUGHT DISORDERS

Illogical thoughts_____ Hallucinations_____ History of psychosis or schizophrenia_____ Paranoid thoughts_____ Erratic or highly variable moods_____

10) TYPE "A" PERSONALITY TRAIT

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

11) 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

<p>Constitutional: Fatigue/Tires _____ Weight Change _____ Fever/Chills/Sweats _____ Appetite Change _____ Abnormal Thirst _____ Difficulty Sleeping _____ Light-Headed _____</p> <p>Eyes: Vision _____ Tearing _____ Itching _____ Feels Heavy _____ Allergic Shiners _____</p> <p>Ears: Itching _____ Hearing Problem _____ Blocked Ears _____ Ringing in Ears _____ Sensitive to Sound _____ Dizziness/Vertigo _____</p> <p>Nose/Throat: Stuffed/Runny Nose _____ Postnasal Drip _____ Sore Throat _____ Tight/Swollen Throat _____ Hoarse Voice _____ Trouble Swallowing _____</p> <p>Mouth: Sores/Fissures _____ Herpes or Frequent _____ Cold Sores _____ Gum/Tooth Problems _____ Tongue Problem _____</p>	<p>Skin: Itching _____ Flushing _____ Rashes _____ Hives _____ Dry/Rough Skin _____ Acne _____ Nail/Hair Problem _____</p> <p>Lymph Nodes: Swollen/Tender _____</p> <p>Lungs/Heart: Cough _____ Wheezing _____ Shortness of Breath _____ Hyperventilation _____ Phlegm/Mucus/Bronchitis _____ Chest Pain or Exertion _____ Other Chest Pain/Distress _____ Palpitations/rapid, Slow _____ Irregular Heart Rate/Rhythm _____ Ankle Swelling _____ Calf Pain on Exercise _____ Sore Tender Legs _____ High Blood Pressure _____</p> <p>Gastrointestinal: Nausea _____ Belching/Bloating Gas _____ Passing Gas _____ Heartburn or Stomach Pain _____ Diarrhea _____ Constipation _____ Cramps or Aches _____ Rectal Pain or Itching _____ Blood or Black Stools _____ Worms or Parasites _____</p>	<p>Muscles: Tight/Stiff _____ Ache/Sore/Pain _____ Neck _____ Shoulder, Upper Back _____ Low Back _____ Extremities _____ Weakness _____</p> <p>Joints: Ache/Pain _____ Stiff _____ Swelling _____</p> <p>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 _____</p> <p>G.U. (Male) Difficulty Voiding _____ Prostate Problem _____ Lump on Testes _____ Sexual Problem _____ Herpes _____</p> <p>Thyroid: Mass or Lump in Neck _____ Cold or Heat Tolerance _____ History of X-Ray to Neck _____ Feel Hyper or Sluggish _____</p>	<p>Neuropsychiatric: Headache (Mild/Moderate) _____ Headache (Severe) _____ Depression/Apathy _____ Anxiety/Irritable _____ Hyperactive _____ Learning Disability _____ "Brain Fog"/Difficulty Concentrating _____ Mood Swings _____ Suicidal _____ Homicidal _____ Numbness, Tingling _____ Faints/Blackouts _____ Seizures/Convulsions _____</p>
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TREATMENTS THAT YOU HAVE TRIED

Please complete as fully as you can.

Instructions for completing the form: Mark **(H)** if a treatment helped you, mark **(W)** if it made you worse, mark **(NC)** if there was no change, or mark **(?)** if you are not sure. If you have not tried a treatment leave that space blank.

Nutritional Treatments			
Hypoglycemia Diet		Food Allergy Elimination Diet	Off Wheat/Gluten
Low Sugar/Carbs		Low Fat Diet	Off Milk Products
No MSG/Nutrasweet		No Artificial Colors, Flavors	Organic Diet
Candida Diet		Increase Vegetables/Fruit	Reduce Caffeine
Multivitamin/Mineral		IV Vitamins	Magnesium
Vitamin B-12 Shots		Other Vitamins	Zinc
Fish Oil		Flax Oil	Primrose Oil
Borage Or Currant		N-Acetyl Cysteine	Glutathione
ENADA		Lipoic Acid	Bioflavanoids
L-Carnitine/Carnitor		Lactobacillus/Acidophilus	COQ10
CDP-Choline		Phosphatidyl Serine	Acetyl L-Carnitine
Tryptophan		Tyrosine	
Herbal Therapies			
St. John's Wort		Ginkgo	Echinacea
Valerian		Black Cohosh/Remifemin	Ginseng
Other			
Mind/Body Therapies			
Deep Breathing		Meditation	Music
Relaxation Tapes		Heart Math	Hypnosis
Prayer		Counseling	Better Sleep
Body Work			
Massage Therapy		Physical Therapy	Chiropractic
Pool Therapy		Walk/Jog	Weights
Trigger Point Injection		Manual Trigger Point Therapy	Stretching
Acupuncture		Electrical Stimulation	
Hormonal Treatments			
T3 Thyroid/Cytomel		Thyroid/Synthroid, Levoxyl	Progesterone
Estrogen		Testosterone	Melatonin
Growth Hormone		Armour (Natural) Thyroid	DHEA
Cortisol/Prednisone			
Blood Pressure Raising Tactics			
Salt/Water		Florinef	Licorice
Proamatine		Beta Blockers/Propranalol	Epogen
Jobst Stockings			

Neurochemical Medicines					
Pamelor/ Nortriptyline		Tricyclic Anti-Depressants		Elavil/ Amitriptyline	
SSRI Anti Depressants		Prozac/Fluoxetine		Paxil	
Zoloft/Setraline		Luvox		Celexa	
Desyrl/Trazadone		Other Anti-Depressants		Serzone	
Wellbutrin		Remeron		Lithium	
Nardil/MAO Inhibitor					
Muscle Relaxants					
Flexeril		Zanaflex		Baclofen	
Sleep Medicines					
Restoril		Ambien		Sonata	
Dalmane		Klonopin		Halcion	
Sinemet/Dopamine		Antihistamines/Benadryl			
Anti-Anxiety					
Valium/Diazepam		Ativan/Lorazepam		Buspar	
Respiradol					
Nerve/Pain Stabilizing Medicines					
Neurontin/ Gabapentin		Low Dose Naltrexone		Gabapril	
Ketamine, Oral		Ketamine Gel		Zofran/ Odansetron	
Aricept/ Galantamine		Dextromethorphan		Amantadine	
Stimulant-Like Medicines					
Ritalin		Phentiramine/Adipex		Provigil	
Pain Medicines					
Aspirin/Ibuprofen		Other NSAID's, e.g., Relafen		Ultram	
Codeine		Cox-2 Inhibitors, e.g., Celebrex, Vioxx, etc.		Methadone	
Percocet/Percodan					
Antibiotics					
Acyclovir/Famvir		Kutapressin		Levaquin	
Zithromax		Doxycycline		Gamma Globulin	

DIAGNOSTIC TESTS

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

Instructions for completing the form: For normal mark (N), for abnormal mark (A), for not sure mark (?). If not done please leave blank. Also estimate the year in which the testing was most recently done, e.g., 1999, 2002, etc.

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	
ANA			
Infections			
Lyme Test		Chest X-Ray	
HIV Antibodies		Sinus C.T. Scan Or MRI	
Hepatitis Antibodies		T.B. Test	
Mycoplasma		Chlamydia	
HHV-6		IgG/IgA Antibody Tests	
Heart/Lung			
EKG		Echocardiogram	
Exercise Stress Test		Pulmonary Function Tests	
Thallium Stress Test		C.T. Scan Of Heart (E.B.T.)	
Other			
Endocrine			
Glucose Tolerance Test		Insulin Level	
HBA1C		DHEAS	
Cortisol		Growth Hormone	
Estrogen		Testosterone	
Prolactin			
Nutrition			
Homocysteine		Magnesium	
Vitamin B-12		Zinc	
Food Allergies		Candida Tests	
Amino Acid Analysis		Organic Acid Analysis	
Essential Fatty Acids		Anti-Gluten (Wheat) Antibodies	
G.I.			
Upper G.I. X-Ray		Colonoscopy	
Upper GI Endoscopy		Sigmoidoscopy	
Small Bowel X-Ray		Helicobacter (H. Pylorus)	
Stool Test for Blood			
Neurology/Psychology			
C.T. Brain		MRI of Brain	
C.T. Cervical Spine		Neurology Consult	
Psychological Consult		EEG	
Sleep Observation (At Home)		Sleep Observation (In Lab)	
Hyperventilation Test			