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 to 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 Treatments 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 1½ to 2 hours. The fee for an Initial Visit is $690.00 with Dr. Podell and $550.00 with Edwina S. King, PhD, APN (Advanced Practice Nurse). 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 typical patient requires a comprehensive initial visit, then follow up visits, ranging from $100.00 to $200.00.

We do not participate with any Health Insurance Company except Medicare. Dr. Podell is no longer accepting new Medicare patients. We will provide you with a receipt that you can submit to your insurance plan for reimbursement. Most patients are eligible for reimbursement under the “Out Of Network” provisions of their policy.

We now have two locations in New Jersey: Springfield and New Brunswick area (105 Morris Avenue, Suite 200, Springfield, NJ 07081, Tel: 973-218-9191, Fax: 793-218-1199) and (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,

Edwina S. King, PhD, APN

Edwina S. King, PhD, APN
Director Behavioral Medicine &
Clinical Research

Richard N. Podell, M.D., M.P.H.
Collaborating Physician
Clinical Professor, Dept. of Family Medicine
UMDNJ-Robert Wood Johnson Medical School

Beverly Licatta, R.N.-**Nurse Educator**

PATIENT INFORMATION FORM

Patient Information

Name (Last, First): ______________________ Date of Birth: ______________

Street Address: ______________________ Social Security #: ______________

City, State, Zip: ______________________ Home Phone: ______________

E-Mail Address: ______________________ Work Phone: ______________

Sex: Male ⑥ Female ⑥ Marital Status: Married ⑥ Single ⑥ Widowed ⑥ Divorced ⑥ Separated ⑥

Employer's Name or School Name: ______________________

Relationship to Insured: Self ⑥ Spouse ⑥ Child ⑥ Other ⑥

Health Insurance Information (Primary)

Health Insurance Name: ______________ Address: ______________

ID#: ______________ Group #: ______________ Plan Name or #: ______________

Name of Insured: ______________ Birth Date: ______________ Social Security #: ______________

Insured's Relationship to Patient: Self ⑥ Spouse ⑥ Child ⑥ Other ⑥

Health Insurance Information (Secondary)

Health Insurance Name: ______________ ID#: ______________ Group #: ______________

Name of Insured: ______________ Birth Date: ______________ Social Security #: ______________

Insured's Relationship to Patient: Self ⑥ Spouse ⑥ Child ⑥ Other ⑥

Financial Responsibility (Person Financially Responsible for Patient Named Above)

Non-Medicare

I understand that Richard N. Podell, MD, does not participate with any health insurance and that payment is due at the time services are rendered. I agree to these payment terms and guarantee payment to Richard N. Podell, MD, for any services provided to the patient named above.

______________________ ______________ ______________

Signature of Guarantor Date Social Security #

Relationship to Patient: Self ⑥ Spouse ⑥ Child ⑥ Other ⑥

Medicare

I authorize the release of any information necessary to process medical claims for the patient named above and authorize that payment of Medicare benefits for these claims be made to our office. Also, I agree to promptly pay for any services not covered by Medicare and or determined by Medicare to be my responsibility (i.e., Deductibles, Co-payments dictated by Medicare such as 20% of the allowable fee for Medical Services and 50% of the allowable fee for Psychological Services when deemed "Reasonable and Necessary", and any charges for Services and/or Laboratory Tests not covered or deemed "Not Reasonable and Necessary").

______________________ ______________ ______________

Signature of Guarantor Date Social Security #

Relationship to Patient: Self ⑥ Spouse ⑥ Child ⑥ Other ⑥

Primary Care Physician: ______________________ Phone: ______________

How did you hear about us? Doctor ⑥ Radio ⑥ Newspaper ⑥ Friend ⑥ Other______________

Name of Pharmacy: ______________________ ***Pharmacy Phone:*** ______________

Drug Allergies: No ⑥ Yes ⑥ If yes, list names:________________________ Prescription Plan? Yes ⑥ No ⑥

Practitioner Use Only

Date	DX	Meds

PATIENT HEALTH HISTORY QUESTIONNAIRE

Your Name_______________________________________ Date______________

DOB:____________________________ Social Security #:______________________

Tel: ________________ Fax: __________________ E-mail:________________

Address:____

City: ___________________________ State:______ Zip:________________________

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)?

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?_____ Which ones?____

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 with bed 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
- 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______ Sjoegren'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

Do you ever fall asleep inappropriately, e.g., at work/school______ while driving______ with other people______ watching T.V. ______?

Sleep schedule: About what time do you usually go to bed?_____________________
About what time do you usually actually fall asleep?_____________________________
About what time do you get up in the morning?________________________________
Subtracting interruptions, how many hours do you actually sleep?_______________

Do you usually need an alarm clock? ______
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? ______ Is initially falling asleep often a problem? ______
Do you wake too often during the night? ______ Do you take naps? ______
Do these refresh you? ______ Are you sleeping much less (say 45 minutes or more) than you used to, e.g., when you were last feeling well? ______

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 when you are asleep for 30 minutes or more? ______ If so, please ask them to observe your breathing for 30 minutes while you are asleep.

Look for struggling for breath, heavy snoring, pauses in breathing of 10 seconds or more. Also look for frequent fine or gross muscle twitching or jerks. (This is important. Sleep disorders are easily overlooked.)

Sleep Apnea: Do you snore? ______ Toss and turn a lot? ______ Cease breathing, snort, or struggle for breathe while you are asleep? ______

Have you had someone observe you? Yes______ No______ Not sure______

Periodic Leg Movement: Has anyone you shared a bed with observed that your muscles often twitch or limbs jerk? ______
(Note: a quick spasm while falling asleep is okay.)

Do you toss and turn a lot/Is the bedding a mess? ______ 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*

Constitutional:
- Fatigue/Tires ____
- Weight Change ____
- Fever/Chills/Sweats ____
- Appetite Change ____
- Abnormal Thirst ____
- Difficulty Sleeping ____
- Light-Headed ____

Eyes:
- Vision ____
- Tearing ____
- Itching ____
- Feels Heavy ____
- Alergic Shiners ____

Ears:
- Itching ____
- Hearing Problem ____
- Blocked Ears ____
- Ringing in Ears ____
- Sensitive to Sound ____
- Dizziness/Vertigo ____

Nose/Throat:
- Stuffed/Runny Nose ____
- Postnasal Drip ____
- Sore Throat ____
- Tight/Swollen Throat ____
- Hoarse Voice ____
- Trouble Swallowing ____

Mouth:
- Sores/Fissures ____
- Herpes or Frequent ____
- Cold Sores ____
- Gum/Tooth Problems ____
- Tongue Problem ____

Skin:
- Itching ____
- Flushing ____
- Rashes ____
- Hives ____
- Dry/Rough Skin ____
- Acne ____
- Nail/Hair Problem ____

Lymph Nodes:
- Swollen/Tender ____

Lungs/Heart:
- Cough ____
- Wheezing ____
- Shortness of Breath ____
- Hyperventilation ____
- Phlegm/Mucus/Bronchitis ____
- Chest Pain on Exertion ____
- Other Chest Pain/Distress ____
- Palpitations/rapid, slow ____
- Irregular Heart Rate/Rhythm ____
- Ankle Swelling ____
- Calf Pain on Exercise ____
- Sore Tender Legs ____
- High Blood Pressure ____

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 ____

Muscles:
- Tight/Stiff ____
- Ache/Sore/Pain ____
- Neck ____
- Shoulder, Upper Back ____
- Low Back ____
- Extremities ____
- Weakness ____

Joints:
- Ache/Pain ____
- Stiff ____
- Swelling ____

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 ____
- Sexual Problem ____
- Herpes ____

Thyroid:
- Mass or Lump in Neck ____
- Cold or Heat Tolerance ____
- History of X-Ray to Neck ____
- Feel Hyper or Sluggish ____

Neuropsychiatric:
- Headache (Mild/Moderat) ____
- Headache (Severe) ____
- Depression/Apathy ____
- Anxiety/Irritable ____
- Hyperactive ____
- Learning Disability ____
- "Brain Fog"/Difficulty Concentrating ____
- Mood Swings ____
- Suicidal ____
- Homicidal ____
- Numbness, Tingling ____
- Faints/Blackouts ____
- Seizures/Convulsions ____

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/Amitryptiline	
SSRI Anti-		Prozac/Fluoxetine		Paxil	

Depressants					
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 Medicines					
Valium/Diazepam		Ativan/Lorazepam		Buspar	
Respiradol					
Nerve/Pain Stabilizing Medicines					
Neurontin/Gabapentin		Low Dose Naltrexone		Gabatril	
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			