



PATIENT HISTORY

(To be completed prior to Initial Visit to the best of your ability)

Date _____

Name (Last) _____ (First) _____ (Middle) _____

Date of Birth _____ Age _____ Sex _____ Wt. _____ Ht. _____

Drug Allergies _____

Food Allergies _____

At what age did you first start having headaches? _____

1. Most commonly, where are your headaches located:

- _____ Behind one eye _____ (left) _____ (right)
- _____ Behind both eyes
- _____ Side of head _____ (left) _____ (right)
- _____ Top of head
- _____ Back of head/neck
- _____ Encompasses entire head

3. Please check other effective measures that you have used for pain relief:

- | | | |
|-----------------|--------------------|--------------------|
| _____ Cold/Ice | _____ Magnets | _____ Accupuncture |
| _____ Heat | _____ Aromatherapy | _____ Botox Inj. |
| _____ Dark room | _____ Herbal pills | _____ TMJ Device |
| _____ Massage | _____ Herbal teas | _____ Other |

- _____ Only Drug Therapy works:
 - _____ over the counter
 - _____ herbal or "natural" products
 - _____ prescription (non-narcotic)
 - _____ prescription (narcotic)

4. Please check any (and all) health care providers that you have previously (or (are currently) seeking treatment from:

	Previously	Currently	Name
Family Practice Physician	_____	_____	_____
Internal Medicine Physician	_____	_____	_____
OB/GYN Physician	_____	_____	_____
Neurologist	_____	_____	_____
Chiropractor	_____	_____	_____
Dentist	_____	_____	_____
Oral Surgeon	_____	_____	_____
Psychiatrist	_____	_____	_____
Ophthalmologist	_____	_____	_____
Psychologist/Therapist	_____	_____	_____
Allergist	_____	_____	_____

5. Were you ever diagnosed with any of the following:

____migraine headaches

____cluster headaches

____tension headaches

____sinus headaches

6. How many meals per day do you usually eat?

____one____two____three____four (or more)____varies

If applicable: ____Pound recent weight gain ____Pound recent weight loss

7. How much caffeine do you drink per day? _____

8. When going to bed for the night, do you fall asleep easily? ____yes ____no

9. When you wake up do you feel refreshed and alert? ____yes ____no

10. Do you generally ____sleep through the night, or do you ____wake frequently?

11. Impact of headaches on family/personal life:

____None ____Slight ____Moderate ____Severe

12. Do you have any beliefs about your headaches as a direct result of your culture?

____No ____Yes (describe)

13. Women only: (If applicable):

Last normal menstrual period _____

Number of pregnancies _____

Number of children _____

14. Any personal history of mental and/or physical abuse that you have experienced?

(describe)

REVIEW OF SYSTEMS:

Please circle any **symptoms you may currently be experiencing.**

CONSTITUTIONAL:	fever, weight loss, change in appetite, fatigue, difficulty sleeping
EYES:	double vision, blurred vision, difficulty focusing, blindness, pain
EARS/NOSE/THROAT:	ringing in the ears, deafness, hearing loss, loss of smell, pain, loss of taste, difficulty swallowing, difficulty speaking, hoarseness
CARDIOVASCULAR:	chest pain, shortness of breath, palpitations, irregular heart beat, high blood pressure, low blood pressure, angina, fainting spells
RESPIRATORY:	cough, difficulty breathing, wheezing, frequent colds
GASTROINTESTINAL:	changes in appetite or thirst, weight loss or gain, nausea, vomiting, heartburn, abdominal pain, jaundice, constipation, diarrhea, bowel incontinence
GENITOURINARY:	urinary frequency, urinary incontinence, urinary retention, prostate problems, impotence, bladder infection(s), kidney stone(s), kidney infection(s)
MUSCULOSKELETAL:	joint pain or stiffness, muscle ache, back pain, neck pain, joint swelling, leg pain, muscle spasms, weakness
SKIN/BREAST:	rash, dryness, stretch marks, discharge, pain, itching, skin cancer
NEUROLOGIC:	dizziness, headaches, blackouts, numbness, tingling, weakness, cramps or spasms, memory loss, difficulty concentrating, head trauma
PSYCHIATRIC:	crying spells, mood swings, depression, vivid dreams, hallucinations
ENDOCRINE:	excessive thirst, increased urination, sweating, dry skin, loss of hair, coarse hair, temperature sensitivity easy to bruise, difficulty clotting, blood clots, anemia, swollen glands
ALLERGIC/ IMMUNOLOGIC:	seasonal allergies, food allergies, frequent upper respiratory tract infections

Please use the below space (or back of this page) for any additional information or comments.

Educational Background

- did not finish High School
- High School Graduate
- 1-2 years College
- Trade or Technical School, List training _____
- 4 Year College Degree, List degree _____
- Master's Degree, List degree _____
- Doctorate

Have you experienced any of the following events in the past year?

- Death of a spouse
- Divorce
- Marital Separation
- Jail term
- Death of a close family member
- Personal injury or illness
- Marriage
- Loss of a job through firing
- Marital reconciliation
- Retirement