APPENDIX K
MEDICAL HISTORY AND LIFESTYLE OVERVIEW

Name: ____ Age: __________ y.o. Date: ______________________

Street Address: ____ Phone: (   ) ___________________________

City: _________________________________ State: ___________________ Zip: ______________

Occupation (job title): ____ ( ) Right-handed ( ) Left-handed

Physicians caring for you: ____

____

Please tell us what is bothering you. If this involves a specific health condition or illness, please tell us about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factors that you think may have played a role in its onset and progression. (Please attach a sheet if more space is required).

____

____

____

____

____

____

Is your health currently getting better, worse, or staying the same? ____________________________

What would you like to have happen as a result of this assessment? ____

____

____

____

How long do you think this will take? ____

Please list any medical problems you have and all previous surgeries:

1. ____ 7. ____

2. ____ 8. ____

3. ____ 9. ____

4. ____ 10. ____

5. ____ 11. ____

6. ____ 12. ____

(Use additional space to give information as needed about these conditions.)

Headache Research Report

List all medications (prescription and non-prescription) that you take now. ____________________

____

____

____

List any other medications that have been tried in the past to treat your symptoms: ____________________

____

____

Please list any allergies or sensitivities you have: ____________________

____

____

What other treatments, if any, have you tried? Put a star by those that have helped. ____________________

____

____

____

How would you describe your health in general? ____________________

During the last year have you had: (check all that apply)

( ) unexplained fevers	( ) night sweats	( ) weight loss of 10 lb. or more
( ) loss of appetite	( ) excessive fatigue	( ) problems with depression
( ) difficulty sleeping	( ) easy bruising	( ) unusual stress in home life
( ) chest pain or tightness	( ) easy bleeding	( ) unusual stress in work life
( ) persistent or unusual cough	( ) swollen ankles	( ) any lumps in neck, armpits, or groin
( ) coughing up blood	( ) stomach pain	( ) trouble breathing with exercise
( ) change in bowel habits	( ) persistent diarrhea	( ) trouble breathing when lying flat
( ) dark black stools	( ) excessive constipation	( ) difficulty starting or stopping urination
( ) bleeding on stools	( ) blood in urine	( ) pain or burning when urinating

What other health practices do you incorporate into your lifestyle at the present time? ____________________

____

____

____

____

____

____

Headache Research Report

Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

a.

b.

c.

d.

e.

Do you think the pain and/or symptoms that you are experiencing could be purposeful? That is, could they be your body's wisdom saying, I need some help... let's change some things here!" Please explain:

____

____

____

Do you feel your pain and/or illness is a reflection of short-term superficial circumstances or longer term, potentially deeper-seated challenges?

____

____

What areas of your lifestyle are likely involved with your condition and you would like to improve:
(Prioritize # 1, 2, 3, etc.)

_____ My level of anxiety

_____ My pace of living

_____ Not enough quiet time and rest diet and nutrition program

_____ My exercise program

_____ Not enough time spent in nature

_____ My creative expression

_____ My feelings around career

_____ My social and family life

_____ My communication skills

Please list any self-destructive lifeslyle habits (e.g. smoking, lack of exercise, addictions, etc.)

____

____

____

Headache Research Report

What might it cost you if you don't significantly improve your lifestyle and any underlying contributors to compromised health? (For example: vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

____

____

What is your present level of commitment to change the underlying causes of problem(s) which relate to your lifestyle? (Rate from 1 to 10, with 10 being 100% committed). _______________

List your 3 highest priorities in life which come to mind and speak to your heart. Where does your health and vitality factor in?
a.

b.

c.

What obstacles could prevent you from changing those lifestyle factors that are undermining your health?

____

____

What might stop you from following the treatment plan that we may prescribe for you?

____

____

Who would be willing to support you in your health goals?

____

____

Please list your special interests and passion:

____

____

Women only:

Age at onset of menstruation: _________ No. of miscarriages/c-sections: ____

Number of children: _________________ Age at onset of menopause: __________________

How was your health as a child? (circle one): excellent good fair poor

Were there any complications with your delivery? Please explain:

____

____

Headache Research Report

Did you have any serious emotional or mental traumas as a child? __________ Please explain:

____

____

____

____

What is your blood type? (circle one): A B AB 0 don't know

Do you wake rested? ______________________________

Please rate your current emotional health (please circle): excellent good fair poor unstable crisis

Are you currently in psychotherapy? _____________ Do you have a good support network/team? _____________

Does your home environment have a supportive effect on your health? _____________

How many hours of relaxation (not including sleep) do you give yourself during the work week? ______________

During weekends? __________ Favorite recreational activities? ____

Do you have amalgam (silver) fillings?__________ Any other dental problems? ______________________________

Are you considering any elective surgery or medical procedures in the near future? ______________________________________

Family Health History

Relation	Age	State Of Health (if living)	Age At Death	Cause of Death	Check if your blood relatives have/had Disease		Relationship
Father						Arthritis, gout	
Mother,						Asthma, hay fever	
Brothers						Cancer	
						Chemical dependency	
						Diabetes	
						Heart disease, stroke	
Sisters						High blood pressure	
						Syphilis, gonorrhea	
						Tuberculosis	
						Other	

What tests have been previously done?

____

____

____

____

What were the results?

____

____

____

____

(Use additional pages as necessary.)

Headache Research Report

Please list everything you eat and drink for 2-3 days:

Time	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

HEADACHE SPECIFIC INFORMATION

Age at onset of headaches: ______________________________

When do the headaches usually begin: ____

Duration: less than 2 hours 2 – 4 hours 4 – 8 hours 8 – 24 hours longer than 24 hours

Triggers, aggravating or alleviating factors: ____

____

Symptoms preceding headache or aura *(prodromal)***:**

_____ Nausea _____ Numbness or tingling _____ Vomiting _____ Diarrhea/constipation

_____ Neck or backache _____ Indigestion _____ Abdominal pain _____ Mood change

_____ Visual disturbances _____ Sensitivity to light _____ Motor disturbance _____ Food Cravings

_____ Other (describe) ____

Symptoms experienced during or after headache: ____

____

Description of pain:

_____ Throbbing _____ Dull Ache _____ Other (*describe*) ________________________

_____ Stabbing _____ Pulsating ____

_____ Pounding _____ Tight band around head ____

Headache Research Report

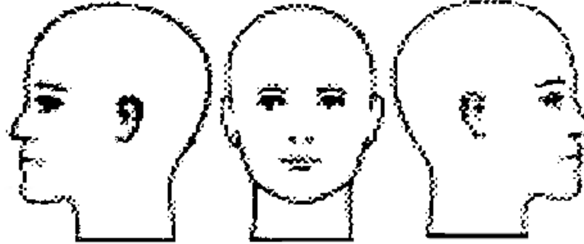
Location of pain:

_____ Front of head _____ Side of head (L or R) _____ Both sides of head

_____ Back of head _____ Behind the eye _____ Top of head

_____ All around the head _____ Other (*specify*)____

(Indicate by drawing where the headache pain is typically located.)



How often do you have headaches?____

Severity: 1 2 3 4 5
not severe most severe

Are the headaches related to the menstrual cycle? _____ Yes _____ No _____ NA If yes, please explain: ___________________

____

Are your headaches related to sleep patterns? _____ Yes _____ No If yes, please explain: ________________________________

____

Have you ever had a back or neck injury? _____ Yes _____ No If yes, please explain: ___________________________________

____

____

____

Have you ever injured your tailbone? _____ Yes _____ No

Is your tailbone sore? _____ Yes _____ No

Is there anything else you would like us to know about you?