Today's Date____________

Social Security #__________

Behavioral Medicine Evaluation Questionnaire

Name____D.O.B.__________

Address/City/State/Zip____

Telephone: Home:________________Work:__________________Ext.__________

Health Insurance____________________________Employer__________________

Policy I.D.#________________________________Group #___________________

Referred by_________________________________Date______________________

Height (barefeet)_____________ Weight (clothed)__________lbs.

What symptoms brought you here?_______________________________________

____

If legal action is pending concerning any of your symptoms, please provide the following information:

Date & Type of Injury____

Attorney: Name & Phone #:____

PART ONE: Medical Inventory

Please list all medical treatments you have had for the above problem. Include medications and operations.

Date	Doctor	Treatment	Results

Please List any other medical problems, past or present:

Date Started	Descriptions

Please list any other hospitalizations you have had:

Date	Descriptions

If you have ever been in counseling or psychotherapy, please list date(s), name(s) of therapist(s), reason(s) for seeking help and the benefits:

Date	Treating Therapist	Treatment	Results

Please list any and all medications you are currently taking (Not including Vitamins, Minerals, Etc.)

Medication	Dosage	How Often Taken	Reason Prescribed	Effects

Part Two

		Frequent	Sometimes	Never
1.	Do you have difficulty relaxing?	___	___	___
2.	Do you have a tendency to worry a lot?	___	___	___
3.	Do you have a tendency to shake or tremble?	___	___	___
4.	Do you bite your nails?	___	___	___
5.	Are you often nervous?	___	___	___
6.	Are you often anxious?	___	___	___
7.	Are you often restless?	___	___	___
8.	Are you often tense?	___	___	___
9.	Do you ever have anxiety attacks?	___	___	___
10.	Do you find it difficult to sit still?	___	___	___
11.	Are you easily startled?	___	___	___
12.	Do you frequently feel keyed up?	___	___	___
13.	Is your energy level unusually high?	___	___	___
14.	Do you have difficulty falling asleep?	___	___	___
15.	Do you have difficulty staying asleep?	___	___	___
16.	Are you often sleepy?	___	___	___
17.	Are you often tired?	___	___	___
18.	Are you troubled by frightening dreams?	___	___	___
19.	Is your energy level unusually low?	___	___	___
20.	Are you often fatigued?	___	___	___
21.	Do little things annoy you?	___	___	___
22.	Do you lose control when you get angry?	___	___	___
23.	Do you lose your temper often?	___	___	___
24.	Do you prefer rooms to be warmer than most people do?	___	___	___
25.	Do you prefer rooms to be cooler than most people do?	___	___	___
26.	Have you a tendency to be too cold?	___	___	___
27.	Have you a tendency to be too hot?	___	___	___
28.	Are your hands and feet often cool?	___	___	___
29.	Do you sweat excessively?	___	___	___
30.	Do you sweat unusually little?	___	___	___
31.	Do you ever hyperventilate?	___	___	___
32.	Do you ever become short of breath?	___	___	___
33.	Is your breathing shallow?	___	___	___
34.	Is your breathing ever irregular?	___	___	___
35.	Do you ever black out?	___	___	___
36.	Do you have sudden episodes of weakness?	___	___	___
37.	Do your legs ever give way when you laugh?	___	___	___
38.	Do you ever feel lightheaded or dizzy?	___	___	___
39.	Does any part of your body ever feel numb?	___	___	___
40.	Do you often feel "pins & needles" in any part of your body?	___	___	___
41.	Do you get headaches more than once a week?	___	___	___
42.	Do your neck muscles feel tense or hurt?	___	___	___
43.	Does your lower back feel tense or hurt?	___	___	___
44.	Do other parts of your body feel tense or hurt?	___	___	___
45.	Do you urinate very often?	___	___	___
46.	Do you often have diarrhea?	___	___	___
47.	Are you often constipated?	___	___	___
48.	Do you often feel gassy?	___	___	___
49.	Do you often have stomach cramps?	___	___	___
50.	Do you often have indigestion?	___	___	___
51.	Do you eat excessively?	___	___	___
52.	Is your appetite excessive?	___	___	___
53.	Is your appetite too small?	___	___	___
54.	Do you clench your teeth?	___	___	___
55.	Do you grind your teeth at night?	___	___	___

PART THREE

A. PLEASE CIRCLE WHICH OF THE FOLLOWING SITUATIONS ARE CURRENTLY STRESSFUL. RANK THEM IN ORDER EG. #1=MOST STRESSFUL AND SAY WHY.
#2=NEXT MOST STRESSFUL

Parents	Work	Symptoms
Children	School	Sex
Spouse	Social Life	Finances
Other Relatives	Other: ____________________	

B. PLEASE ANSWER THE FOLLOWING QUESTIONS:

	YES	NO
1. When your symptoms first began, were you under much stress?...............	___	___
2. Are you currently under much stress?....................................	___	___
3. Do your symptoms vary with stress?....................................... Describe how ____________________	___	___
4. Do your current stresses bother you much?................................	___	___
5. Are you perfectionistic?...	___	___
6. Do you drive yourself hard?..	___	___
7. Do you often feel guilty when you relax?.................................	___	___
8. Do you often exhaust yourself?...	___	___

PART FOUR

1. Do you feel unfulfilled?..	___	___
2. Would you feel fulfilled if not for your symptoms?.......................	___	___
3. Are you lonely?..	___	___
4. Do you cry often?..	___	___
5. Are you often sad?...	___	___
6. Do you withdraw socially?..	___	___
7. Do you find it difficult to enjoy anything?..............................	___	___
8. Do you often wish that you did not exist?................................	___	___
9. Do you feel that others would be better off if you were dead?............	___	___

PART FIVE

1. Do you have trouble concentrating?..	___	___
2. Do you get confused at times?..	___	___
3. Do you often forget what you were saying in the middle of it?............	___	___
4. Are you forgetful?...	___	___
5. Is it difficult to think clearly?..	___	___
6. Do you get lost easily?..	___	___
7. Is your memory not as good as it used to be?.............................	___	___
8. Has your mind not been as clear since your symptoms began?...............	___	___
9. Do you have trouble understanding what others are saying?................	___	___
10. Do you feel you are less intelligent than you used to be?...............	___	___
11. Do you have difficulty in making decisions?.............................	___	___

PART SIX

A. PLEASE LIST ANY VITAMIN OR MINERAL SUPPLEMENTS YOU ARE TAKING:

____

B. PLEASE LIST WHAT YOU EAT AND DRINK ON A TYPICAL DAY. INCLUDE ALL SNACKS:

FOOD/BEVERAGE	HOUR OF DAY	FOOD/BEVERAGE	HOUR OF DAY

C. PLEASE LIST YOUR AVERAGE DAILY CONSUMPTION OF THE FOLLOWING:

number of cigarettes:		glasses other regular soft drinks:	
number of cigars/pipes:		glasses of other diet soft drinks:	
cups of regular coffee:		cans of beer:	
cups of decaffeinated coffee		glasses of red or rose wine:	
glasses of regular cola:		glasses of white wine:	
glasses of diet cola:		shots (ounces) of hard liquor:	

D. IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE EXPLAIN YOUR ANSWER IN DETAIL AT THE END OR USE ADDITIONAL PAPER:

	YES	NO
1. Do your symptoms vary with the seasons?..................................		
2. Do your symptoms vary with the time of day?..............................		
3. Do your symptoms vary with the weather?.................................		
4. Do your symptoms vary with geographic location?......................		
5. Do your symptoms vary with your exact location (car, home, garden, office, kitchen, etc.)?..		
6. Did you make any changes in your environment shortly before your symptoms began (moving, gas appliances, etc.)?.........................		
7. Did you have colic as an infant?..		
8. Did you ever have asthma or hay fever?..................................		
9. Were you ever sensitive to any foods or drugs?.........................		
10. Are you allergic to any medications?.......................................		
11. Is your skin sensitive to any substances (clothes, make-up, etc.)?........		
12. Have you ever had any allergies not already listed?.....................		
13. Does anyone in your immediate family have a history of allergy?...........		
14. Has your weight changed since your symptoms began?......................		
15. Do you have a strong craving for any foods?.............................		
16. Do you have a strong craving for alcoholic beverages?....................		
17. Do your symptoms awaken you in the middle of the night?...................		
18. Do you need to eat or drink something in the middle of the night?.........		

QUESTION #	EXPLANATION

CIRCLE No or Yes... Please answer ALL questions even though some are repeated

1. Do you sometimes see colored rings around lights?........................ No Yes
2. Have you had attacks of redness and pain in one eye?...................... No Yes
3. Do you get a headache after looking into bright light?.................... No Yes
4. Do you get a headache after using your eyes excessively?.................. No Yes
5. Is the pain mainly in the back of your neck?.............................. No Yes
6. Do you have a pain that feels like a tight band around your head?........ No Yes
7. Is the pain dull and steady?... No Yes
8. Does the pain disappear when you rest or relax?........................... No Yes
9. Is the pain on the top of your head?...................................... No Yes
10. Have you had this type of headache all your life or at least for many years?.. No Yes
11. Does the pain stop completely during a vacation?.......................... No Yes
12. Is your headache not really a pain but rather a discomfort or pressure feeling?.. No Yes
13. Do you sometimes have the feeling you cannot take a deep breath or get enough air?... No Yes
14. Is the pain improved when you lie down?................................... No Yes
15. Do you see "spots" before your eyes before or during the attacks?........ No Yes
16. Do you like to do everything just perfect?................................ No Yes
17. Are you a very emotional person?.. No Yes
18. Does your headache occur periodically?.................................... No Yes
19. Does your headache usually start on one side?............................. No Yes
20. Is the headache associated with nausea and vomiting?...................... No Yes
21. Is the pain throbbing or pulsating?....................................... No Yes
22. Does the headache wake you out of a sleep?................................ No Yes
23. Do your eyes water or your nose get stuffy when you have a headache?.... No Yes
24. Does the attack begin and end suddenly?................................... No Yes
25. Are there sudden attacks of severe pain involving the eyes and temples?. No Yes
26. Do you have short attacks of pain several times a day?.................... No Yes
27. Does one or both eyes get inflamed with attacks of pain?.................. No Yes
28. Does your face get red on one side with the headache?..................... No Yes
29. Do you have headaches sometimes on one side and other times on the other side?.. No Yes
30. Do the blood vessels on your temples swell during the attack?............ No Yes
31. Does the pain become worse when you lie down?............................. No Yes
32. Do you smoke more than one pack a day?.................................... No Yes
33. Do you drink more than one or two alcoholic drinks a day?................ No Yes
34. Have you recently stopped drinking coffee?................................ No Yes
35. Do you have headache when you turn your head?............................. No Yes
36. Do you suffer from arthritis or rheumatism?............................... No Yes
37. Is your headache mainly over the forehead or the cheek bones?............ No Yes
38. Do you have a discharge from your nose or frequent cough?................. No Yes
39. Do you get fever with the headache?....................................... No Yes
40. Do you have continuous headache all the time?............................. No Yes
41. Is the pain aggravated by cough?.. No Yes
42. Do you have attacks of vomitting without nausea?.......................... No Yes
43. Do you have attacks of convulsions?....................................... No Yes
44. Did this type of headache occur recently and never in the past?.......... No Yes
45. Is the pain always on the same side of the head?.......................... No Yes
46. Did the headache start after an injury?................................... No Yes
47. Do you have, or have you had in the past, any ear trouble?................ No Yes
48. Do you need dental care?.. No Yes
49. Do you skip breakfast or eat irregularly?................................. No Yes