New York Headache Center

www.NYHeadache.com

Patient Information

Date _____ Date of birth_____Place of birth_____

Name _____ Marital status _____

Street address _____

Home phone _____ Business phone _____

e-mail _____ Cell phone _____

Social security # _____ Occupation _____

Employer _____

Street address _____

Insurance_____

In case of emergency contact:

Name_____ Relationship_____ Phone_____

Name and phone number of the pharmacy you use _____

Referring physician_____

Street address/phone _____

Any other doctors you would like us to send a report to _____

Referred by (friend, media, etc.)_____

Reason for this visit _____

_____

_____

_____

Manhattan
30 East 76th Street,
New York, NY 10021
Tel: 212-794-3550

Westchester
99 Maple Avenue,
White Plains, NY 10605
Tel: 212-794-3550

At what age did you have your first headache: _____ What year did your current headaches begin: _____

When was your last headache: _____

Are you ever free of pain completely? ☐ Yes ☐ No

Do you have more than one type of headaches? ☐ Yes ☐ No

If yes, describe them separately: _____

_____

How many headaches (any type) do you have each month: _____, how long do they last: _____

How would you describe the pain of your most serious headaches (circle one or several):

Throbbing pulsating dull aching pressure-like sharp stabbing electric-like

vise-like hot burning sickening blinding unbearable punishing vicious exhausting

Does the pain feels like
☐ going from outside – in (compressing, stabbing in) or ☐ from the inside – out (exploding, pushing out).

When you have a headache (and possibly after), do your scalp and face become sensitive to touch and do you avoid putting on glasses, jewelry or combing your hair? ☐ Yes ☐ No

Are your headaches brought on by:

your periods/hormonal changes exercise stress relaxation after stress change in weather alcohol

bright light/glare odors smoke noise lack of sleep too much sleep hunger food additives

certain foods

Do your headaches occur on any particular day of the week or time of day: _____

_____

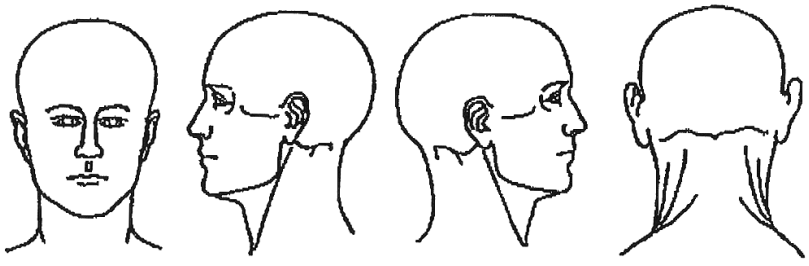
Do you have any warning signs before the start of a headache: ☐ Yes ☐ No

Describe: _____

Circle any of the following symptoms you have with your headaches:
Neck pain Nausea Vomiting Light sensitivity Dizziness Noise sensitivity Numbness Weakness Fever
Confusion Difficulty speaking Tearing Nasal congestion Eyelid drooping Worsening of pain with movement Other:

_____

Please indicate with x's where you experience pain



Have you ever been treated for headaches: ☐ Yes ☐ No

What kind of headaches were you told you have: _____

Have you had any tests done to diagnose your headaches: ☐ Yes ☐ No

Describe: _____

Which of the following medicines have you tried for headaches (of any kind) (circle):

Anaprox	Codeine	Imitrex/Sumatriptan	Percogesic
Aspirin	Darvon/Darvocet	Inderal/Propranolol	Phrenilin Forte
Anacin	Dexamethasone/Decadron	Indocin/Indomethacin	Relpax
Advil/Ibuprofen	Decongestants	Lamictal	Robaxin
Aleve/Naproxen	DHE-45	Lidocaine	Stadol
Amerge	Demerol	Lithium	Talwin
Axert	Depakote	Lyrica	Topamax/Topiramate
Axotal	Desyrel/Tradozone	Maxalt	Tylenol
Amitriptyline/Elavil	Dilantin/Phenytoin	Migralex	Ultram/Tramadol
Atacand	Effexor	Migranal	Ultracet
Benicar	Esgic	Motrin/ibuprofen	Valium
Beta-blockers	Ergostat	Neurontin/gabapentin	Vivactyl/Protriptyline
Botox	Excedrin	Naprosyn/Anaprox	Wigraine
Bufferin	Fioricet/butalbital	Panadol	Xanax
Cafergot	Fiorinal/butibital	Pamelor/nortriptyline	Zanaflex
Calan / verapamil	Flexeril	Percocet/oxycodone	Zomig
Cymbalta	Frova	Percodan	Zonegran
			Other:

* Star those which helped, even for a while.

Have you tried any of he following alternative treatments (circle):

Biofeedback Acupuncture Chiropractic Physical Therapy Other:

Supplements (feverfew, B2, magnesium, MigreLief, CoQ10, butterbur, Petadolex)

List all the headache medications and the amounts you are now taking (over the counter or prescribed):

_	_	_
_	_	_
_	_	_
_	_	_

List all other medicines you are taking for any reason:

_	_	_
_	_	_
_	_	_
_	_	_

Midas Questionnaire | Migraine Disability Assessment

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor findthe best treatment for you.

INSTRUCTIONS: Please answer the following questions about all of your headaches over the last 3 months.
Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months.

1. On how many days in the last 3 months did you miss work or school because of your headaches? (If you do not attend work or school enter zero in the space to the right.) . ☐

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend school or work enter zero at right.) . ☐

3. On how many days in the last 3 months did you not do household work because of your headaches? . ☐

4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend school or work enter zero at right.) . ☐

5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches? ☐

A. On how many days in the last 3 months did you have a headache?
(If headache lasted more than 1 day, count each day.). ☐

B. On a scale of 0-10, on average, how painful were these headaches?
(Where 0=no pain at all, and 10=pain which is as bad as it can be.). ☐

Add the total number of days from questions 1 to 5 (ignore A and B). ☐

During the past month

1. Have you been bothered a lot in the last month by feeling sad, down, or depressed? ☐ Yes ☐ No

2. Have you been bothered a lot in the last month by a loss of interest or pleasure in your daily activities? ☐ Yes ☐ No

For men: When was the last time you had more than five drinks in one day?
☐ Never ☐ In the past three months ☐ Over three months ago

For women: When was the last time you had more than four drinks in one day?
☐ Never ☐ In the past three months ☐ Over three months ago

Have you had any of the following problems in the past 6 months:

- ☐ Change in marital status
- ☐ Change in job/school
- ☐ New illness diagnosed
- ☐ Emotional trauma
- ☐ Change in smoking/drinking/diet
- ☐ Hospitalization/surgery
- ☐ Fatigue
- ☐ Bruising
- ☐ Weight loss _____ lbs, gain _____ lbs
- ☐ Allergic reaction
- ☐ Skin rash
- ☐ Sweating
- ☐ Fever/chills
- ☐ High blood pressure
- ☐ Palpitations
- ☐ Breathing difficulty
- ☐ Chest pain
- ☐ Swelling
- ☐ Chronic cough
- ☐ Wheezing
- ☐ Bleeding/bruising
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Nausea/vomiting
- ☐ Joint pain/swelling/redness
- ☐ Muscle aches
- ☐ Sexual dysfunction
- ☐ Breast lumps/discharge
- ☐ Symptoms of menopause
- ☐ Irregular periods/menstrual problems
- ☐ PMS
- ☐ Bladder problems
- ☐ Cold hands and feet
- ☐ Leg/foot cramps
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Anxiety/panic attacks
- ☐ Irritability
- ☐ Change in skin/hair
- ☐ Excessive urination or thirst
- ☐ Insomnia
- ☐ Leg restlessness
- ☐ Daytime sleepiness
- ☐ Snoring
- ☐ Bad dreams
- ☐ Sleep apnea
- ☐ Teeth grinding/clenching
- ☐ Seizures/shaking
- ☐ Headaches
- ☐ Back pain
- ☐ Neck pain
- ☐ Feeling spacey/brain fog
- ☐ Decline in memory
- ☐ Weakness
- ☐ Numbness
- ☐ Hearing problems
- ☐ Noise in your ears
- ☐ Vision problems
- ☐ Redness of the eyes
- ☐ Loss of consciousness
- ☐ Dizziness
- ☐ Poor coordination/balance
- ☐ Dental problems
- ☐ Sinus problems
- ☐ Hoarseness
- ☐ Any other problems not listed

Please list all your present medical problems and doctors you are seeing: _____

_____

_____

_____

Please list all past medical problems, operations, hospital admissions: _____

_____

_____

_____

Please list your allergies, if any _____

_____

What is your height _____ Weight _____

Amounts per day: Alcohol _____ Coffee _____ Tea _____ Tonic/soda _____ Water _____

If you smoke, how much? _____ Recreational drugs ☐ yes ☐ no

What time do you go to sleep and wake up? Weekdays_____ Weekends_____

Physical exercise/frequency/duration: _____

Present work status:_____ Do you like your job ☐ yes ☐ no ☐ not sure

If you have children, please list their ages: _____

Please list hobbies/recreational activities: _____

What is your current level of stress (0 = no stress; 10 = catastrophic): _____

Level of education:_____ Do you have pets: _____

With whom are you living: (list relationship and ages):_____

Are there any serious problems at home? ☐ Yes ☐ No Describe (if yes): _____

Is there a family history of (please check):

☐ Headaches	☐ Arthritis	☐ Mental illness	☐ Other
☐ Seizures	☐ Alcoholism	☐ Obesity	
☐ Strokes	☐ Goiter/Thyroid	☐ Excessive bleeding	
☐ Heart disease	☐ Diabetes	☐ Cancer	
☐ High blood pressure	☐ Tuberculosis	☐ Sleep disorders	

Information Release

I request that payment of authorized insurance benefits be made on my behalf to Physicians Pain Treatment Associates (New York Headache Center) for any services furnished me by physicians at the Center. I authorize any holder of medical information about me to release to the Health Financial administration and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT NAME _____

PATIENT'S SIGNATURE _____

DATE _____ / _____ / _____

Patient Financial Agreement

Dear Patient
As a service to our patients, our office accepts assignment of most major medical plans. However, in the current managed care environment, reimbursement for certain services has been increasingly difficult to obtain. In addition, most in-office procedures now require pre-certification or referral. In an effort to continue to give our patients excellent, yet affordable care, we ask that you take time to read and sign the following agreement. This will enable us to continue to submit insurance claims on behalf of our patients.

I understand that I must have a current referral on file for every office visit and that it is my responsibility to obtain referrals from my PCP, according to the guidelines of my plan. If a referral is not obtained I understand I will be responsible for the office visit.

I understand that co-payments must be paid at the time of service.

I understand that I will be responsible for all deductibles, co-insurances and unpaid "allowable amounts".

I understand that the doctor has agreed to accept assignment from my insurance carrier for services rendered in the office if participating.

I understand that it is my responsibility to update my insurance information on file and give a copy of my insurance card.

I understand that certain services (CPT Code# _____) performed by the doctor may not be covered under my insurance as outlined in policy. If the insurance denies payment, I will personally and fully be responsible for the payment.

CANCELLATION POLICY
I understand I must give the office 24 hours advance notice in order to cancel my appointment. If an appointment is not cancelled within the 24 hour notice or I do not call to cancel an appointment (NO SHOW) I will be charged $50.

PATIENT NAME _____

PATIENT'S SIGNATURE _____

DATE _____ / _____ / _____

HIPPA Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

1. Uses and Disclosures of Protected Health Information
Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice. And any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Heathcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. This situations include: us Required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect, Food and Drug Administration requirements; Legal Proceedings: Law Enforcement _____, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and required by the Secretary ok Department of health and Human services to investigate or determinate our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy tour protected health information.

Under federal law, however, you may not inspect or copy following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected heath information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternatives means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complains: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practice:

PATIENT NAME _____

PATIENT'S SIGNATURE _____

DATE _____ / _____ / _____