Headache Wellness Center

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1414 Yanceyville St.
Greensboro
NC 27405

Dear Patient,

Welcome to Headache Wellness Center. We are pleased you have chosen our office for your headache care.

Please take a moment to read this important information.

Please arrive 30 minutes before your scheduled appointment time so that we can enter your information in our database.

Please note that due to the nature of our practice, you may be at our office for up to **3 hours** during your initial evaluation. Please schedule other obligations accordingly.

Please use this checklist to make sure you bring the following things with you:

- □ All enclosed forms **completed**.
- □ Insurance card(s) and any other information that will assist in filing insurance for you.
- □ Medical records of past headache evaluations and treatments.
- □ Laboratory records, EKG's (within 6 months), x-rays, and MRI/CT scan reports. Additional lab work may be necessary at the time of your visit. Please make sure you are fully hydrated 24 hrs prior to your appointment, as this will ensure a more successful blood draw.
- □ Names, addresses and phone numbers of other professionals with whom we should be communicating.
- □ **ALL** medications that you are currently taking, including over-the-counter and herbal.

INSURANCE

Please be sure to identify your insurance plan when scheduling your appointment. **Any pre-authorizations required by your insurance are your responsibility.**

We are pleased to participate in many insurance plans. As a courtesy, our insurance department will file your insurance claim for you. In order to provide this service, we will need a copy of your insurance card and a signed authorization form.

APPOINTMENT CONFIRMATION

Enclosed you will find an important reminder card. ***You must confirm your appointment by phone two (2) business days prior to your scheduled appointment. If we do not hear from you, your appointment will be cancelled. Once you have confirmed, please contact us ASAP if you are unable to keep your scheduled appointment.***

Jackie Ostasiewski
Office Administrator

Turn over for map

HEADACHE WELLNESS CENTER & EMG/EEG CONSULTANTS
Notice of Privacy Practices
Effective Date: 09/23/2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Continued…

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at ***HEADACHE WELLNESS CENTER & EMG/EEG CONSULTANTS.*** If you have questions and would like additional information, you may contact us at 336-574-8000.

HEADACHE WELLNESS CENTER

Acct # _____
Date: _____
Staff Review:_____

PHI Disclosure/Consent

Patient Name:_____ DOB:_____

Authorization to Use/Release protected health information:

I authorize Headache Wellness Center to use/disclose my health information (including mental health, drug and/or alcohol abuse, and HIV/AIDS diagnosis) to anyone in these categories, for these purposes:

- Report treatment to a referring physician
- Report treatment to Primary Care Doctor for Coordination of Care
- Insurance Carrier for Reimbursement, Authorizations, Benefit verification
- Referrals for services outside of our office
- Routine office operations, i.e., pharmacy
- Research data collection – no identifying information
- Refer to Notice of Privacy Practice for complete listing

Permission to Discuss Protected Health Information

I give Headache Wellness Center permission to discuss treatment and billing issues with the person(s) listed below. In order to obtain information, the person must be listed below and know your identifying information (I.E., DOB, SS#, Etc). NO WRITTEN INFORMATION will be shared without an additional consent form specifically for releasing written information.

Name	Relationship	Ph #

Phone and Email Communication

You have the right to receive communication from us in a confidential manner as stated in our Privacy Policy. In the normal operations of our business, we may attempt to contact you when you are not available. Due to privacy laws, we cannot leave detailed messages if your voice mail does not identify your name and/or phone number. If we are having trouble reaching you by phone, we may email you if you have provided an email address. In the future, we may offer educational or practice information by email. **Please indicate your preferences on communication from our office.**

Email: □ HWC **may** send me educational or practice information by email.

□ **Do not** send detailed patient information in an email

Phone: ***Please note***: You **WILL NOT** receive appointment reminders if you select either of these options.

□ **Do not** leave detailed messages with other people that may answer the phone

□ **Do not** leave detailed messages on voice mails

At your initial appointment in our office, you are given a complete explanation of Headache Wellness Centers "Notice of Privacy Practices". Our office reserves the right to change this information. You will be given a copy of any updates of this notice at your first visit following any change. You may ask for a copy at any time.

I acknowledge that I have received an initial copy of Headache Wellness Center's Notice of Privacy Practices. I understand that I can ask questions regarding their Privacy Practices at any time.

This authorization shall be in effect until revised, treatment is complete or authorization is revoked-in writing. I understand that this will not apply if action has already taken place under this authorization.

_____ _____

Patient Name Date

HEADACHE WELLNESS CENTER

Acct # _____
Date: _____
Staff Review:_____

Patient Information

Patient Name:_____
First Name MI Last Name Preferred Name

Address: _____
Street City State Zip +

Home # (___) _____ Cell # (___) _____ Work # (___) _____ Ext ____

Email Address: _____ **Circle Preferred Communication: Home/Cell/Email**

DOB:_____ SS# _____ Gender: ☐Male ☐Female

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐ Separated ☐ Other: _____

Race: ☐Asian ☐Black/African American ☐Caucasian/White ☐Hispanic/Latino ☐Native American ☐Other:_____

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino
Primary Language: (only if not English) _____

Emergency Contact: _____
Name Phone # Relationship

If patient is a minor: Parent Name: _____ Ph #: _____
☐ Same Address as pt Address:_____
Street City State/Zip

Referring MD:_____ Ph #:_____
Name City/State
Primary MD:_____ Ph #:_____
Name City/State

Important Office Information

Please Read and Sign Below

- Appointments for specialty care in our office are in high demand. We respectfully request 24 hour notice of cancellation or rescheduling of appointments. Please contact our office as soon as you are aware that you are unable to attend your appointment so that we can offer the appointment to another patient.
- Due to an increasing amount of no show appointments, a charge of $35.00 will be billed to you if you do not call us 24 hours prior to your appointment. This charge cannot be billed to your insurance company and will have to be paid in order to reschedule a missed appointment.
- Any patient who has three missed appointments will be considered for dismissal from the practice.
- We are committed to providing the best treatment options for our patients. Please help us serve you better by keeping your scheduled appointments. Please understand that you will be provided the number of refills needed until your next appointment. If you do not keep scheduled appointments, refill requests may be denied until your next appointment.
- We do not accept third party liability (i.e., accidents) or new Workers Compensation patients. If your treatment is related to either of these, please stop here and contact our office.
- Our office does not provide disability for headache disorders. All requests for letters or FMLA paperwork will incur a $25.00 charge.

_____ _____
Patient Name Date

HEADACHE WELLNESS CENTER

Acct # _____
Date: _____
Staff Review:_____

Insurance Information

Please bring your insurance card(s) and photo ID with this completed and signed form.

Patient Name: _____ **DOB:** _____

Primary Insurance Company:_____
Policy ID#:_____ Policy Group #:_____
Policy Holder's Employer:_____ Ph # _____

Policy's Holder's relationship to patient: □ Self □ Spouse □ Parent □ Other _____
Policy Holder's Name: _____ DOB:_____
Policy Holder's Address: _____/ □ Same as patient_____
_____
Phone#:_____/ □ Same as patient SS# _____

Secondary Insurance Company:_____
Policy ID#:_____ Policy Group #:_____
Policy Holder's Employer:_____ Ph # _____

Policy's Holder's relationship to patient: □ Self □ Spouse □ Parent □ Other _____
Policy Holder's Name: _____ DOB:_____
Policy Holder's Address: _____/ □ Same as patient_____
_____
Phone#:_____/ □ Same as patient SS# _____

Insurance/Payment Information

- ⇨ **Payment is expected at the time of service.** As a courtesy, we will file your visit with your insurance company. All Copayments, Deductibles, and Coinsurance portions are expected in full upon checking in for your appointment. Patients who have a deductible that has not been met will need to speak to our office regarding estimates for services that will be rendered.
- ⇨ While most of our services are covered by most insurance plans, please keep in mind that every plan has different coverage guidelines. **Your insurance coverage is a contract between you and your insurance carrier.** You should be familiar with the coverage you have chosen. Having insurance is not a substitute for payment. As a courtesy, we contact your insurance company for benefit information. We provide you with estimates of your cost based on the information received. This is not a guarantee of payment or coverage.
- ⇨ We do not accept Worker's Compensation, third party payers or litigation patients.

- ⇨ You authorize Headache Wellness Center to release any information acquired in the course of examination and treatment to my insurance carrier for the purpose of insurance claim payment.
- ⇨ You authorize payment of my insurance benefits directly to Headache Wellness Center.
- ⇨ You understand that you are financially responsible for all charges not covered by your insurance carrier.

_____ _____
Patient Name Date

Headache Wellness Center

Acct#:_____

Date: _____

E-Prescribing Consent Form

Staff Review: _____

E-Prescribing is a safe and effective way for your physician to send accurate, error-free prescriptions directly to the pharmacy of your choice.

Please list your preferred LOCAL pharmacy below:

_____

Pharmacy Name Location Phone Number

If your insurance company provides a Mail Order Pharmacy for you to use, please list below:

_____

Mail Order Pharmacy Location Phone Number

Electronic communication with your pharmacy is now becoming a standard of care for all patients and is an important element in improving the quality of patient care. The benefits of this program include:

Formulary and benefit transactions –Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

Fill status notification –Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

Understanding all of the above, I hereby provide informed consent to Headache Wellness Center to enroll me in the e-Prescribe program. All prescriptions are sent electronically directly to pharmacies.

By signing this consent form you are agreeing that Headache Wellness Center can request and use your prescription medication history from other healthcare providers and/or third- party pharmacy benefit payers' for treatment purposes.

I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient Name Printed Patient DOB

_____ _____

Signature of Patient or Guardian Date

Headache Wellness Center

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EMERITUS
FACP, FAHS, FAAN

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CLINICAL TRIALS AT THE HEADACHE WELLNESS CENTER

Headache Wellness Center strives to maintain excellence in the treatment of head pain. We are continually reading and attending national meetings to remain current on the latest treatments available for headaches.

As part of our drive to provide the latest and best treatment for our patients, we work with the pharmaceutical industry on evaluating new medications for headaches. Migraine headaches are now receiving much attention from researchers. Many headaches are now leading to many promising new medications to treat migraine headaches. We have been involved in numerous clinical trials since 1994. The results have been encouraging and we are excited about the future.

If you are interested in helping to evaluate new migraine medications, we invite you to join this partnership. If you qualify, you can enroll in one of our clinical trials. You will be given detailed information on the studies that interest you and best fits your schedule.

Clinical trials are not for everyone. You should not feel obligated to participate. If you choose to participate in a study, you will hopefully find a medication that helps you. Regardless of personal benefit, your contribution will provide important information that will benefit millions of headache sufferers.

Thank you for your time and interest in considering headache research. We are happy to answer any questions you may have. For additional information, please call 336-574-8001.

Best Regards,

Headache Wellness Center
Research Team

1414 Yanceyville St.
Greensboro
NC 27405

(336) 574-8000
FAX (336)574-8008
www.headachewellnesscenter.com

Headache Wellness Center

Date_____

Name_____ Age_____ Gender M F Race_____

Referring Physician _____ Primary Care Physician_____

Other physicians to whom you would like our report sent_____

Have you been evaluated at our practice previously? Y N Date/year_____

Has a relative been evaluated at our practice? Y N Name_____ Relationship_____

Please answer all of the following questions. If you are unsure of the answers give your ***best guess***.

When did your headaches first start?_____How many types of headaches do you have?_____

How many *days* in the past 4 weeks (28 days) did you have headaches? (total must equal 28 days-Do not √)
#Severe headaches_____#Moderate headaches_____#Mild headaches_____#No headache_____

How many days in the past 4 weeks (28 days) did you need to take medication for headaches?
(0-28)_____ (Do not count preventive medications)

Do your headaches have any of the following features or associations? (check all that apply)

Pain Intensity: ☐Severe ☐Moderate ☐Mild
Location: ☐Right side ☐Left side ☐Frontal ☐Temporal ☐Eyes ☐Back of head ☐Neck ☐Shoulder
Duration: ☐Seconds ☐Minutes ☐30 minutes ☐1-2 hours ☐4 hours ☐4-12 hours ☐12-24 hours
☐All day ☐2 days ☐3 days ☐> 3 days
Quality: ☐Throbbing ☐Pressure ☐Sharp ☐Dull ☐Burning ☐Tight ☐Stabbing
Associations: ☐Nausea ☐Vomiting ☐Light Sensitive ☐Sound Sensitive
☐Odor Sensitive ☐Worse with Movements/Activities ☐Dizzy
Visual Changes: ☐Blurred ☐Dark Spots ☐White Spots ☐Flashing Lights
☐Jagged Lines ☐Blind Spots ☐Tunnel Vision ☐Double Vision

Describe your headaches _____

_____

_____

_____

Headache Impact Test (HIT-6)

When you have headaches, how often is the pain severe? NEVER RARELY SOMETIMES OFTEN ALWAYS

How often do headaches limit your ability to do usual daily activities, including household work, work, school, or social activities? NEVER RARELY SOMETIMES OFTEN ALWAYS

When you have a headache, how often do you wish you could lie down? NEVER RARELY SOMETIMES OFTEN ALWAYS

In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches? NEVER RARELY SOMETIMES OFTEN ALWAYS

In the past 4 weeks, how often have you felt fed up or irritated because of your headaches? NEVER RARELY SOMETIMES OFTEN ALWAYS

In the past 4 weeks, how often did headaches limit your Ability to concentrate on work or daily activities? NEVER RARELY SOMETIMES OFTEN ALWAYS

6_____8_____10_____11_____13_____

During the past 4 weeks, how different would your life have been without headaches?
1. Completely different 2. Very different 3. Somewhat different 4. Not much different 5. Not at all different

Female Patients Only:
Are you pregnant or contemplating pregnancy?_____
Are you breast-feeding? Y N _____
Are you able to bear children? Y N (If not, why not?)_____
Are you using birth control? Y N (what type/which one?)_____
Are you currently having menstrual periods? Y N (if not, why not?)_____
Are your menstrual periods regular? Y N _____
Have you had a hysterectomy? Y N Were your ovaries removed? Y N
Are you taking hormone replacement therapy? Y N (which one?)_____
Are your headaches related to your periods? If so, in what way? _____
_____
_____

RESEARCH: Would you be willing to participate in a clinical research trial for headaches?
Yes___ No___

How did you hear about Headache Wellness Center? Doctor referral____ Friend/Relative____ Newspaper____
Radio ad___ Internet/web____ TV____ Formerly a patient____ Other (please specify)_____

Please visit Headache Wellness Center on the web at **www.headachewellnesscenter.com**

MEDICATIONS

Please list ALL current medications and DOSAGES
Include prescription, OTCs, herbal, and vitamin products you are currently taking
Please bring all medications with you to your appointment

Current medications

Medication Name	Daily Dose (mg)	Date Started	Degree of Relief	Side Effects

Past medications you have taken for your headaches

Medication Name	Daily Dose (mg)	Date Started	Degree of Relief	Side Effects

Please list any **MEDICATION ALLERGIES** (include allergies to dyes or contrast material, latex, sulfa, etc.)

Previous treatments for headache (doctor's name & year)

Neurologist_____	Dentist_____	Chiropractor_____
Family doctor_____	Gynecologist_____	Acupuncture_____
ENT_____	Eye_____	Allergist_____
Psychologist_____	Psychiatrist_____	Biofeedback_____
Botox_____	Nerve Blocks_____	Trigger point injections_____
Surgery_____	Other_____	_____

***Previous tests for headache*: PLEASE BRING A COPY OF SCANS OR REPORTS WITH YOU**

Test	***When?***	***By whom and where?***	***Results?***
CT brain scan			
MRI brain/neck			
Skull/sinus/spine x-rays			
EEG			
LP (spinal tap)			
ECG			
Blood tests			

Please check any factors below that seem to trigger headaches:

___allergies	___weather	___medications	___exposure to
___food	___plane travel	___jaw movement	___environmental hazards
___beverages/alcohol	___hurrying	___head injury	
___fatigue	___worrying	___periods	___other
___not enough sleep	___seasonal changes	___hormone changes	
___sleeping late	___odors	___vacation	
___skipping meals	___exertion	___sinus problems	
___glare/sun	___sex	___emotional stress	

FAMILY HISTORY: Do any of your blood relatives have the following disorders:

High blood pressure: Yes No Who?_____
Diabetes: Yes No Who?_____
Heart disease: Yes No Who?_____
Cancer: Yes No Who?_____
Mental illness or nervous disease: Yes No Who?_____
Stroke: Yes No Who?_____

Has anyone else in your family had headaches? (for example: grandparent, uncle, aunt, cousin, etc.)

_____
_____

PAST MEDICAL HISTORY: Please check (√) **all** that apply. Please check all disorders for which you have had or are currently using medications. If a medical condition is not listed, please enter it in the space below.

___acid reflux (GERD)
___ADD/ADHD
___alcohol/substance abuse
___allergies
___aneurysm (brain)
___anorexia
___anxiety disorder
___arthritis
___osteoarthritis
___rheumatoid arthritis
___asthma
___BIPOLAR DISORDER
___blood clots
location:_____
___brain tumor
___bulimia
___cancer
type:_____
type:_____
___cholesterol (elevated)
___chronic fatigue syndrome
___COPD
___congestive heart failure
___coronary artery disease
___with stent placement
___coronary artery bypass (CABG)
___Crohn's disease
___deep venous thrombosis (DVT)
___depression
___diabetes mellitus
___diet-controlled
___insulin-required
___emphysema
___FIBROMYALGIA
___heart attack (MI)
___high blood pressure
___HIV/AIDS
___insomnia/sleep disorder
___interstitial cystitis
___irritable bowel syndrome (IBS)
___kidney disease
___dialysis
___kidney stones
___neuropathy
___numbness, tingling, or pain of hands/feet
___osteopenia
___osteoporosis
___overweight/obese
___panic attacks
___peripheral vascular disease
___pseudotumor cerebri
___psychiatric disorder
type:_____
type:_____
___pulmonary embolism (PE)
___Raynaud's disorder
___restless legs syndrome (RLS)
___sleep apnea
___CPAP machine
___using machine
___not using machine
___smoker
___current smoker
___former smoker
___seizure disorder
___epileptic seizures
___pseudoseizures
last event (date):_____
___SLE (lupus)
___stroke
___suicide attempt
___thyroid disorder
___low(hypo)thyroid
___high(hyper)thyroid
___TIA
___triglyceride problems
___tumor
type:_____
type:_____
___ulcerative colitis

OTHER:_____
OTHER:_____
OTHER:_____
OTHER:_____

PAST SURGICAL HISTORY: Please list all prior surgeries and hospitalizations

surgery/hospitalization	*year*	*surgery/hospitalization*	*year*

_____

_____

_____

_____

_____

<u>REVIEW OF SYSTEMS</u>: Please check (√) those that have occurred recently

GENERAL
__appetite change
__chills
__abnormal sweating
__low energy
__fatigue
__fever
__lethargy
__recent weight change

EYES
__discharge
__drooping
__glaucoma
__eye pain
__contact lenses
__abnormal vision

EARS, NOSE, THROAT
__ear pain
__ear discharge
__abnormal hearing
__buzzing, ringing
__ vertigo
__nasal discharge, blood
__hay fever, allergies
__nasal congestion
__sinus problems
__snoring
__problems with teeth
__mouth pain
__hoarseness
__sore throat
__tongue pain, burning

RESPIRATORY
__asthma
__bronchitis
__cough
__coughing up blood
__abnormal sputum
__shortness of breath
__wheezing

HEART
__chest pain
__swelling ankles/feet
__heart murmur
__high blood pressure
__irregular or rapid heart
__heart disease
__high cholesterol

GI
__abdominal pain
__abdominal swelling
__constipation
__diarrhea
__abnormal "gas"
__food intolerance
__heartburn
__ulcers
__hepatitis
__liver abnormality
__nausea or vomiting
__regurgitation
__bloody or black stools
__trouble swallowing

GU
__abnormal periods
__abnormal sexual interest
__poor sexual function
__sex related disease
__loss of urine control
__bloody or dark urine
__increase / decrease urine
__urine infections
__pain with urination
__kidney stones

MUSCULOSKELETAL
__arthritis
__joint abnormalities
__back pain
__arm / leg pain
__muscle weakness
__muscle pain/cramps

NEUROLOGICAL
__walking abnormalities
__decreased balance
__blackouts
__abnormal sensations
__racing thoughts
__abnormal thinking
__seizures / convulsions
__ dizziness / lightheaded
__fainting
__memory loss
__numbness / tingling
__speech abnormality
__tremors

SKIN
__sensitivity to sunlight
__change in moles
__change in hair
__skin abnormality / rash
__breast lump / discharge

PSYCHIATRIC
__personality change
__depression
__sadness, crying
__compulsive behaviors
__fussy / irritable /hostile
__mood swings
__restless
__sleep abnormalities
__stress / tension
__eating abnormalities
__hyperactive
__abnormal behaviors
__suicidal thoughts

ENDOCRINE
__thyroid disease
__ sugar diabetes
__hormone abnormality

HEMATOLOGIC
__anemia
__abnormal bleeding
__abnormal bruising
__swollen nodes
__HIV/AIDS

other_____
_____
_____
_____

SOCIAL HISTORY

Did you have a happy childhood? Yes ___No___ If not, why not?_____
Have you ever been a victim of abuse? Y___N___: If yes, what type? Physical ___Sexual ___Verbal/emotional___
Educational level/Grade completed _____Marital status_____
Do you have children? Yes___ No___ # of children____ Ages of children_____
Occupation/Former occupation (if retired)_____
Job satisfaction: Minimal___ Moderate___ Great___
Job stress: Minimal___ Moderate___ High___ Type of stress_____
Are you disabled/currently on disability? Yes ___No___
Beverage consumption (# per day):
#Coffee _____#Tea _____#Soda _____#Juice _____#Other (specify)_____
Do your beverages contain caffeine? Yes___ No ___
Alcohol use:
days per week _____Type _____History of alcoholism/problems with alcohol?_____
Tobacco use:
Have you ever smoked? Yes___ No___ Packs/day_____ #years smoked_____
Current smoker_____ Former smoker_____ Quit date/year_____
Do you use dip/snuff? Yes___ No___ Cans/day_____ #years using dip/snuff_____
Drug use:
Are you currently using drugs? Yes___ No___ Type of drug(s)_____
Have you previously used drugs? Yes___ No___ Type of drug(s)_____
Exercise: # days/week _____Time per day _____minutes Type of exercise_____
What do you do for fun? _____
Describe your present emotional stressors _____
_____

SLEEP HISTORY

Difficulty falling asleep? Y___ N___ Difficulty staying asleep? Y___N___ Awaken refreshed? Y___N___
Hours in bed_____ Hours asleep_____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g. theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Headache Wellness Center -- Medication List

Patient Name: _____ Date: _____

Please **UNDERLINE** each medication you have used in the **PAST**. Please **CIRCLE** each medication you are **CURRENTLY** using.

ANALGESICS
Actiq/Fentanyl
Anacin/Aspirin/Bufferin
BC/Goody's
Codeine/Tylenol #3or4
Combunox/ Ibup-Oxycodone
Darvon/Darvocet/Propoxyphene
Demerol/Mepergan
Dilaudid/Hydromorphone
Duragesic/Fentanyl
Equagesic
Esgic/Phrenalin
Excedrin
Fioricet/Fiorinal/Butalbital
Kadian/Morphine
Lidoderm patch/Lidocaine
Lorcet/Lortab/Hydrocodone
MS Contin/MSIR
Nubain/Nalbuphine
OxyContin/OxyIR
Percocet/Percodan/Tylox
Tylenol/Acetaminophen
Sedapap
Stadol/Butorphenol
Talwin/Pentazocine
Ultram/Ultracet/Tramadol
Vicodin/Vicoprofen

ANTI-MIGRAINE

Amerge
Axert
Bellergal
Cafergot/Wigraine
Cambia
DHE-45 injection or IV
DHE
Droperidol
Ergomar/Ergotrate
Frova/Frovatriptan
Imitrex injection
Imitrex nasal spray
Imitrex tablet
Lidocaine nasal
Maxalt
Methergine
Midrin/Duradrin
Migralex
Migranal/DHE nasal spray
Onzetra
Relpax
Sansert
Sumavel Dose Pro
Treximet
Zecuity
Zomig tablets/Zolmitriptan
Zomig nasal spray

HEART/BP
Atacand/Candesartan
Blocadren/Timolol
Calan/Verelan/Verapamil
Capoten/Catapril
Cardene/Nicardipine
Cardizem/Diltiazem
Catapres/Clonidine
Coreg/Carvediol
Corgard/Nadolol
Inderal/Propranolol
Lopressor/Toprol/Metoprolol
Lotensin/Benazepril
Lotrel
Norvasc/Amlodipine
Procardial/Nifedipine
Tenormin/Atenolol

DECONGESTANT/ ANTIHISTAMINE
Allegra/Fexofenadine
Antivert/Meclizine
Beconase
Benadryl
Clarinex/Claritin
Entex/guaifenesin
Flonase
Naldecon
Nasonex
Periactin/cyproheptadine
Sudafed/Pseudoephedrine
Zyrtec/Cetirizine

ANTI-NAUSEANT
Compazine/Prochlorperazine
Dramamine
Reglan/Metoclopramide
Phenergan/Promethazine
Tigan/Trimethabenzamide
Vistaril/Atarax/Hydroxyzine
Zofran/Ondansetron

NSAID's
Advil/Motrin/Ibuprofen
Aleve/Anaprox/Naproxen
Ansaid/Flurbiprofen

Cataflam/Voltaren/Diclofenac
Celebrex
Clinoril/Sulindac
Daypro/oxaprozin
Feldene/Piroxicam
Indocin/Indomethacin
Lodine/Etodolac
Meclomen/Meclofenamate
Mobic/Meloxicam
Naprosyn/Naproxen
Orudis/Ketoprofen
Relafen/Nabumetone
Toradol/Ketorolac

MUSCLE RELAXANTS
Amrix/Cyclobenzaprine ER
Flexeril/Cyclobenzaprine
Liorisol/Baclofen
Norflex/Orphenadrine
Norgesic
Parafon Forte/Chlorzoxazone
Robaxin/Methocarbamol
Skelaxin/Metaxalone
Soma/Carisoprodol
Zanaflex/Tizanidine

ANTI-CONVULSANTS
Depakote/Valproic/Divalproex
Dilantin
Gabitril/Tiagabine
Keppra/Levetiracetam
Klonopin/Clonazepam
Lamictal/Lamotrigine
Lyrica/Pregabalin
Neurontin/Gabapentin
Phenobarbital
Tegretol/Carbatrol/Carbamazepine
Topamax/Topiramate
Trileptal/Oxycarbazepine
Vimpat/Lacosamide
Zonegran/Zonisamide

STEROIDS
Decadron/Dexamethasone
Hydrocortisone
Medrol/Methylprednisone
Prednisone

SLEEPING PILLS/ TRANQUILIZERS
Abilify/Aripipazole
Ambien/CR/Zolpidem
Ativan/Lorazepam
BuSpar/Buspiron
Dalmane/Flurazepam
Halcion/Triazolam
Horizant(gabapentin enacarbil)
Librium/Clordiazepoxide
Lunesta/Eszopiclone
Melatonex/Melatonin
Prosom/Estazolam
Restoril/Temazepam
Rozerem/Ramelteon
Seroquel/Quetiapine
Silenor/doxepin
Sonata/Zaleplon
Thorazine/Chlorpromazine
Tranxene/Clorazepate
Trilafon/Perphenazine
Tylenol PM
Valium/Diazepam
Xanax/Alprazolam
Zolpimist/zolpidem spray
Zyprexa/Olanzapine

ANTI-DEPRESSANTS
Brintillex
Celexa/Citalopram
Cymbalta/Duloxetine
Desipramine/Norpramine
Desyrel/Trazodone
Effexor/Venlafaxine
Elavil/Amitriptyline
Fetzima
Ketamine
Lexapro/Escitalopram
Eskalith/Lithium
Luvox/Fluxamine
Nardil/phenelzine
Pamelor/Nortriptyline
Paxil/Preva/Paroxetine
Pristiq
Prozac/Sarafem/Fluoxetine
Remeron/Mirtazapine
Serzone/Nefazodone
Sinequan/Doxepin
Symbyax
Tofranil/Imipramine
Viibryd
Vivactil/Protriptyline
Wellbutrin/Buproprion
Zoloft/Sertraline

HERBAL
Butterbur
Coenzyme Q10
Feverfew
Magnesium
Riboflavin/Vit B2
Migrelief

FIBROMYALGIA
Cymbalta/Duloxetine
Lyrica/Pregabalin
Savella/Milnacipran

HORMONAL
Allese
Climara
FemHRT
Mircette
Orthoevra Patch
Seasonale
Vivelle Dot
Yasmine

OTHER medications used for headaches not listed

_____
_____
_____
_____

Procedures for headaches
Botox/Botulinum Toxin
Cefaly
Myobloc
Nerve Blocks
Trigger point injections

over

Name: _____ Date: _____

Please check a response for each of the following:	None or a little of the time	Some of the time	Part of the time	Most or all of the time
1. I feel downhearted, blue and sad				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping through the night				
5. I eat as much as I used to				
6. I enjoy looking at, talking to, and being with attractive women/men				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to do				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to				
21. I feel more nervous and anxious than usual				
22. I feel afraid for no reason at all				
23. I get upset easily or feel panicky				
24. I feel like I'm falling apart and going to pieces				
25. I feel that everything is all right and nothing bad will happen				
26. My arms and legs shake and tremble				
27. I am bothered by body aches, neck and back pains				
28. I feel weak and get tired easily				
29. I feel calm and can sit still easily				
30. I can feel my heart beating fast				
31. I am bothered by dizzy spells				
32. I have fainting spells or feel faint				
33. I can breathe in and out easily				
34. I get feelings of numbness and tingling in my fingers, toes				
35. I am bothered by stomachaches or indigestion				
36. I have to empty my bladder often				
37. My hands are usually dry and warm				
38. My face gets hot and blushes				
39. I fall asleep easily and get a good night's rest				
40. I have nightmares				

IN CONSIDERATION OF OUR PATIENTS WHOSE HEADACHES ARE CAUSED BY SCENTS, PLEASE DO NOT WEAR PERFUMES, COLOGNES, AFTERSHAVE, SCENTED POWDERS, OR SCENTED LOTIONS TO OUR OFFICE

THANK YOU

Headache Wellness Center & EMG/EEG Consultants is located at
1414 Yanceyville Street Greensboro, NC 27405 Phone: 336-574-8000

U.S. 29 South
(From Danville/Roanoke, VA or Reidsville)
1. Take the Cone Blvd. Exit turning right onto Cone Blvd.
2. Turn left onto Yanceyville St.
3. We will be on the left (after the Post Office on the right and before the Wendover Ave. overpass).

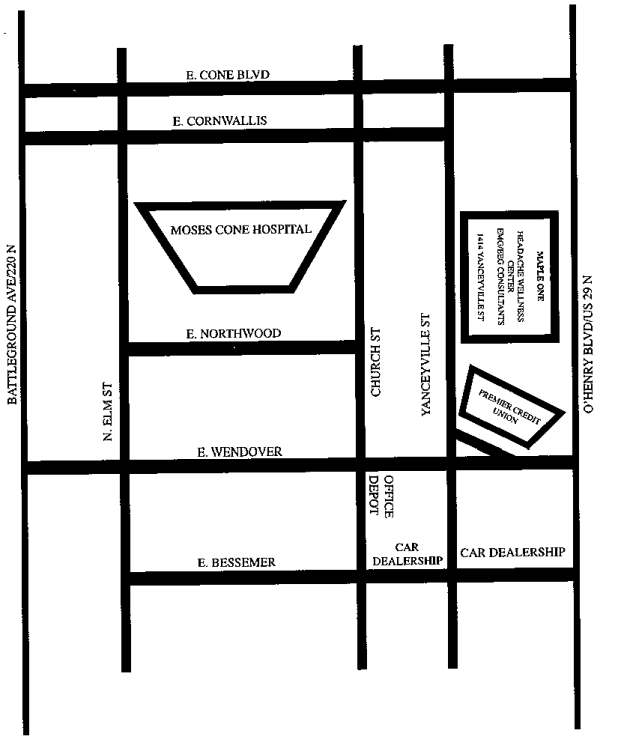
I-40 East / I-85 North
(From Hickory/Kernersville/Statesville/Winston Salem)
1. Stay in the right three lanes heading towards Greensboro.
2. Continue until you reach exit 223 for 29N toward Reidsville.
3. Exit onto E. Wendover Ave WEST (exit after bridge)
4. After Summit Ave, take Yanceyville St Exit (Red Cross Donation Center also on sign).
5. Take a right on Yanceyville.
6. Turn right on 3rd left and immediate left into our parking lot

I-40 West / I-85 South
(From Fayetteville/ Raleigh)
1. Take exit 227 onto 840 N.
2. Turn Right onto 70 West (this becomes Wendover Ave).
3. Go under the bridge at Summit Ave, take the Yanceyville St exit. Take a right onto Yanceyville.
4. Turn right on 3rd left and immediate left into our parking lot

U.S. 220 North
(From Asheboro / Rockingham / Pinehurst)
1. Take exit 79-A to I-85 N Business (toward Burlington).
2. Continue on 40 East until you reach exit 223 for 29N toward Reidsville.
3. Exit onto E. Wendover Ave WEST (exit after bridge)
4. After Summit Ave, take Yanceyville St Exit (Red Cross Donation Center also on sign).
5. Take a right on Yanceyville.
6. Turn right on 3rd left and immediate left into our parking lot

U.S. 220 South
(From Martinsville, VA)
1. U.S. 220 South (becomes Battleground Ave)
2. Turn left onto Cone Blvd.
3. Turn right onto Yanceyville St.
4. We will be on your left (after the Post Office on the right and before the Wendover Ave. overpass).

U.S. 421 East
(From Boone / Wilkesboro / Yadkinville)
1. From U.S. 421 East, go to I-40 East.
2. Stay in the right three lanes heading towards Greensboro.
3. Continue until you reach exit 223 for 29N toward Reidsville.
4. Exit onto E. Wendover Ave WEST (exit after bridge)
5. After Summit Ave, take Yanceyville St Exit (Red Cross Donation Center also on sign).
6. Take a right on Yanceyville.
7. Turn right on 3rd left and immediate left into our parking lot



U.S. 421 North
(From Liberty / Sanford)
1. At 40 junction, take 29N toward Reidsville.
2. Exit onto E. Wendover Ave WEST (exit after bridge)
3 After Summit Ave, take Yanceyville St Exit (Red Cross Donation Center also on sign).
4. Take a right on Yanceyville.
5. Turn right on 3rd left and immediate left into our parking lot

I-85 Business North
(From Charlotte/Kannapolis/Salisbury/Lexington)
1. From I-85 Business North (toward Burlington), Merge with 40 East - take U.S. 29.
2. Exit onto E. Wendover Ave WEST (exit after bridge)
3. After Summit Ave, take Yanceyville St Exit (Red Cross Donation Center also on sign).
4. Take a right on Yanceyville
5. Turn right on 3rd left and immediate left into our parking lot