



Headache Wellness Center

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. **Your arrival time is listed on the green card enclosed.**

Please note that due to the nature of our practice, you could be at our office for up to 2 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. Please include reports for MRI's, CT Scan, X Rays that are headache related.
- 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.
- A complete list of **ALL** medications that you are currently taking, including over-the-counter and herbal.

INSURANCE

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. If you have any changes in insurance, please contact our office prior to arriving. **Any pre-authorizations and network participation requirements by your insurance are your responsibility.**

APPOINTMENT CONFIRMATION

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.

Marshall C. Freeman, MD
FAHS, FAANEM, FAAN

Diplomate American Board
of Psychiatry & Neurology (N)

Diplomate American Board of
Electrodiagnostic Medicine

Diplomate in Neuromuscular
Medicine, ABPN

Diplomate Headache Medicine

Jackie Ostasiewski
BAS
Office Administrator

1414 Yanceyville St.
Greensboro
NC 27405

(336) 574-8000
FAX (336) 574-8008

www.headachewellnesscenter.com

Jackie Ostasiewski
Office Administrator

**Turn over for map
and directions**

**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 Third Street and immediate left into our parking lot

I-40 West / I-85 South

(From Fayetteville/ Raleigh)

1. Take exit 227 onto 840 N.
2. Take Exit 18 and 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 Third Street and immediate left into our parking lot

U.S. 73/220 North

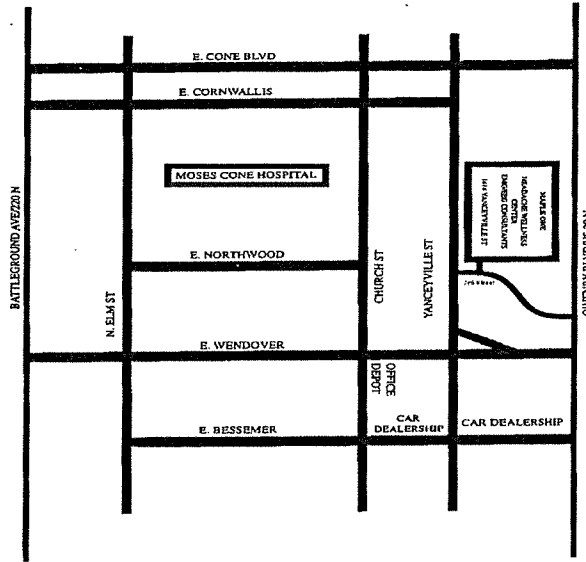
(From Asheboro / Rockingham / Pinehurst)

1. Take exit 79-A to I-40 (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 Third Street 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 Third Street 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 Third Street 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 North (Exit 223)
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 Third Street and immediate left into our parking lot

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 a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI 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 while 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.

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 (I.e., 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 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.



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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.

Jackie Ostasiewski
BAS
Office Administrator

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

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 OR Parent/Guardian Signature

Date

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. 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/Appointment Reminders

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 generally do not leave detailed messages in your voice mail. If we are having trouble reaching you by phone, we may email you if you have provided an email address. Our appointment reminders use all sources of contact (email, phone, and text) that you listed. Should you not want to receive emails or text messages, you can opt out using the methods indicated in the reminder message. Should you not want any appointment reminders, please indicate this to our staff.

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 OR Parent/Guardian Signature

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# _____

.....
**IMPORTANT INFORMATION – Please read and sign
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 OR Parent/Guardian Signature

Date

Headache Wellness Center

Acct#: _____

E-Prescribing Consent Form

Date: _____

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

Mail Order Pharmacy	Location	Phone Number
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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 Parent/Guardian

Date

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

(Office Staff Use ONLY) 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 REPORTS WITH YOU

<u>Test</u>	<u>When?</u>	<u>By whom and where?</u>	<u>Results?</u>
CT brain scan _____			
MRI brain/neck _____			
X-rays (Circle Type) Skull/sinus/spine _____			
EEG _____			
LP (spinal tap) _____			
ECG _____			
Blood tests _____			

Please check any factors below that seem to trigger headaches:

<input type="checkbox"/> allergies	<input type="checkbox"/> weather	<input type="checkbox"/> medications	<input type="checkbox"/> exposure to
<input type="checkbox"/> food	<input type="checkbox"/> plane travel	<input type="checkbox"/> jaw movement	<input type="checkbox"/> environmental hazards
<input type="checkbox"/> beverages/alcohol	<input type="checkbox"/> hurrying	<input type="checkbox"/> head injury	
<input type="checkbox"/> fatigue	<input type="checkbox"/> worrying	<input type="checkbox"/> periods	<input type="checkbox"/> other
<input type="checkbox"/> not enough sleep	<input type="checkbox"/> seasonal changes	<input type="checkbox"/> hormone changes	
<input type="checkbox"/> sleeping late	<input type="checkbox"/> odors	<input type="checkbox"/> vacation	
<input type="checkbox"/> skipping meals	<input type="checkbox"/> exertion	<input type="checkbox"/> sinus problems	
<input type="checkbox"/> glare/sun	<input type="checkbox"/> sex	<input type="checkbox"/> 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

<i>surgery/hospitalization</i>	<i>year</i>	<i>surgery/hospitalization</i>	<i>year</i>
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

REVIEW OF SYSTEMS: 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 no, why? _____
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

<u>Situation</u>	<u>Chance of Dozing</u>			
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

updated 8.24.2021

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

ANTI-CGRP

Aimovig (erenumab)
 Ajovy (fremanezumab)
 Atogepant
 Emgality (galcanezumab)
 Rimegepant/Nurtec
 Ubrovly/ubrogepant
 Vyepti/eptinezumab

HEART/BP

Accupril/Quinapril
 Altace/Ramipril
 Atacand/Candesartan
 Avapro/Irbesartan

Benicar/Olmesartan
 Blocadren/Timolol
 Bumex/Bumetahide
 Bystolic/Rebivolol
 Caduet
 Capoten/Catapril
 Cardene/Nicardipine
 Cardura/Doxazosin
 Catapres/Clonidine
 Coreg/Carvediol
 Corgard/Nadolol
 Covera/Isosin/Calan/Verapamil
 Cozaar/Losartan
 Demadex/Torsemede
 Dilacor/Tiazac/Cardizem/Diltiazem
 Diovan/Valsartan
 Dyazide/Triamterene-HCTZ
 Hydrodiuril/HCTZ/hydrochlorothiazide
 Inderal/Propranolol
 Lasix/Furosamide
 Lopressor/Toprol/Metoprolol
 Lotensin/Benazepril
 Lotrel
 Micardis/Telmisartan
 Minoxidil
 Monopril/Fosinopril
 Nimodipine
 Norvasc/Amlodipine
 Pindolol
 Plendil/Felodipine
 Procardial/Nifedipine
 Sectral/Acebytoll
 Tenormin/Atenolol
 Trandate/Labetolol
 Vasotec/Enalapril
 Zaroxolyn/Metolazone
 Zebeta/Bisoprolol
 Zestril/Prinivil/Lisinopril

**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
 Belsomra/suvorexant
 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
 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/levomilnacipran
 Ketamine
 Lexapro/Escitalopram
 Eskalith/Lithium
 Luvox/Fluoxetine
 Nardil/phenelzine
 Pamelor/Nortriptyline
 Paxil/Preva/Paroxetine
 Pristiq/desvenlafaxine
 Prozac/Sarafem/Fluoxetine
 Soma/Mirtazapine
 Serzone/Nefazodone
 Sinequan/Doxepin
 Spravato/esketamine
 Symbyax/olanzapine & fluoxetine
 Trintellix/vortioxetine
 Tofranil/Imipramine
 Viibryd/vilazodone
 Vivactil/Protriptyline
 Wellbutrin/Bupropion
 Zoloft/Sertraline
 Zulresso/brexanolone

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

Procedures for headaches

Botox/Botulinum Toxin
 Cefaly
 Myobloc
 Nerve Blocks
 Trigger point injections

OTHER medications used
 for headaches not listed

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. <u>I eat as much as I used to</u>				
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. <u>I get tired for no reason</u>				
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. <u>I am more irritable than usual</u>				
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. <u>I still enjoy the things I used to</u>				
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. <u>I feel that everything is all right and nothing bad will happen</u>				
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. <u>I can feel my heart beating fast</u>				
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. <u>I am bothered by stomachaches or indigestion</u>				
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. <u>I have nightmares</u>				