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Patient Registration Form

Demographic Information

Patient Name: _____ Social Security # (optional): _____

Date of Birth: _____

Mailing Address: _____

City: _____ State & Zip: _____

Primary Phone: _____ Alternate Phone: _____
☐Home ☐Work ☐Cell ☐Other ☐Home ☐Work ☐Cell ☐Other

Email Address: _____ Can we leave detailed medical information on voicemail?
☐ Yes ☐ No Or with family? ☐ Yes ☐ No

Provider Information

Referring Provider: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State & Zip: _____

Primary Care Provider: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State & Zip: _____

Are you in the care of any other providers? If so, please list.

Provider: _____ Specialty: _____

Phone: _____ Fax: _____

Provider: _____ Specialty: _____

Phone: _____ Fax: _____

Provider: _____ Specialty: _____

Phone: _____ Fax: _____

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Pharmacy Information

Local Pharmacy: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State & Zip: _____

Mail Order Pharmacy: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State & Zip: _____

Emergency Contact Information

Emergency Contact: _____ Phone: _____

Relationship: _____

Additional Emergency Contact: _____ Phone: _____

Relationship: _____

Insurance Information

Primary Insurance Company Name: _____ Provider Services Phone Number: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____
(if different from patient)

Secondary Insurance Company Name: _____ Provider Services Phone Number: _____

Subscriber's Name: _____ Subscriber' Date of Birth: _____
(if different from patient)

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Medical/Headache History Forms
Instructions & Descriptions

General:

Because AHC treats headache sufferers of all types, these forms ask lots of questions – many of which may not apply to you, personally. Therefore, please follow these guidelines:

- Read through each form.
- Complete each form, as it applies to you. If a question doesn't apply, has already been answered, or doesn't make sense, you may leave it blank.
- If, as you are filling out a form, you have a question about what to do, feel free to call us, and we will help you.
- It helps if you have filled out the forms prior to your visit, because it helps prepare you to make the most of your time with us. However, we recognize that it may not always be feasible. You may always fill them out at the office when you arrive.

Form Description

- **Medical History** - This form covers your medical history in general (not your headaches), and is the same as you see at your primary doctors' office. It covers things such as: chronic medical conditions, surgeries, allergies, medications, social history, family history, and review of other symptoms.

- **Headache History** - This form covers your headache history, specifically. It covers things such as: frequency, how long they have been occurring, potential complicating factors, current treatments, alternative approaches, and prior testing.

- **Headache Description** - This form is for you to describe what you experience during a headache. It covers things such as: onset, location, severity, duration, character of the pain, associated symptoms, and triggers. ***If you have more than one type of headache***, *then please fill out a separate Headache Description Form for each type.*

- **Previous Medications** - This form is for you to check off all the medications you may have used/tried for headache treatment before. It may be particularly helpful if you have been on many different medications over time, or if you are having trouble recalling the names of medications you have tried in the past.

Thank you!

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MEDICAL HISTORY FORM

Date:	Name:		DOB/Age:
Height/Weight:	BP/Pulse	Referring MD:	Right / Left Handed

MEDICATIONS: (Please list medications and dosages)

Rx	Dosage

BLOOD THINNERS: ☐Coumadin ☐Plavix ☐Aspirin ☐Other: _____

ALLERGIES (Please list any allergies to medications):

Rx	Reaction

PAST MEDICAL HISTORY: (please check ALL that apply)

☐AIDS/HIV	☐Alcohol problems	☐Asthma	☐Atrial fibrillation
☐Balance problems	☐Bleeding disorder	☐Blood clots	☐Cancer (type?) _____
☐Carpal Tunnel Syndrome	☐Chemical Dependency	☐Depression	☐Diabetes
☐Epilepsy/Seizures	☐Emphysema/COPD	☐Fibromyalgia	☐Hearing Loss
☐Heart Attack	☐Heart Disease	☐High Blood Pressure	☐High Cholesterol
☐Kidney disease	☐Liver disease	☐Low back pain	☐Neck pain
☐Neuropathy	☐Osteoporosis	☐Pneumonia	☐Rheumatoid Arthritis
☐Sciatica	☐Stroke/TIA	☐Thyroid Problems	☐Tremors
☐Ulcers	☐Vertigo	☐Other: _____	☐Other: _____

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PAST SURGICAL HISTORY, MAJOR ILLNESSES, or HOSPITALIZATIONS (not listed above)

Year	Surgery, Major Illness, or Hospitalization

CONSTITUTIONAL SYMPTOMS (mark any symptoms that you have had recently, and aren't listed in your Past Medical History):

General
☐Fever
☐Fatigue
☐Loss of appetite
☐Significant weight loss

Dermatology
☐Itching
☐Redness
☐Rash
☐Lumps
☐Skin cancer

Endocrinology
☐Excessive sweating/thirst
☐Temperature intolerance
☐Lactation

Ophthalmology
☐Vision Loss
☐Blurring of vision
☐Double vision

Neurology
☐Memory problems
☐Tremors
☐Balance difficulty
☐Numbness
☐Weakness
☐Speech difficulties
☐Dizziness
☐Seizures

Hematology
☐History of transfusions
☐Easy bruising

Cardiology
☐Chest Pain
☐Palpitations
☐Irregular heart beat
☐Leg swelling

Gastroenterology
☐Abdominal pain
☐Heartburn
☐Nausea
☐Vomiting
☐Blood in stool

ENT/Respiratory
☐Ringing in ears
☐Shortness of breath
☐Sleep apnea
☐Cold & Cough
☐Change in voice
☐Difficulty swallowing

Musculoskeletal
☐Joint pain
☐Joint swelling
☐Joint stiffness
☐Muscle aches

Psychology
☐Anxiety
☐Depression
☐Sleep disturbance

Genitourinary
☐Difficulty urinating
☐Urinary urgency
☐Increased frequency
☐Incontinence

FAMILY MEDICAL HISTORY:

Please list any known medical problems (in addition to headaches) in the family:

Father ☐Alive ☐Deceased _____
Mother ☐Alive ☐Deceased _____
Siblings _____
Children _____
Other _____

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SOCIAL HISTORY:

Occupation (if retired, list previous occupation): _____

Hobbies/interests: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Children: ☐# of children _____ ☐Ages of children _____

Caffeine (coffee/tea/soda-pop/other):	☐Yes	☐No	# cups/day_____
Alcohol (beer/wine/liquor):	☐Yes	☐No	#/week _____
Marijuana:	☐Yes	☐No	
Tobacco (smoke/chew/other):	☐Yes	☐No	#/day _____
Recreational drugs (please be truthful):	☐Yes	☐No	☐Current ☐Previous

Sleep: do you…

☐Have trouble falling asleep/staying asleep/both ☐Fall asleep frequently during the day ☐Require naps

☐Snore ☐Have Insomnia ☐Have diagnosed Sleep Apnea

Exercise: How many days per week do you exercise? _____

Type(s): _____

_____

Emotional Health (check any that apply):

☐Anxiety	☐Diagnosed personality disorder	☐Suicide attempt
☐Depression	☐Spousal abuse: current / prior	☐Bipolar Disorder
☐Irritable	☐Significant family stressors/Unstable family situation	☐Psychiatric hospitalization

NOTES (Other things you wish us to know): _____

_____

_____

_____

_____

_____

_____

Thank you!

Occupational:
Have you filed a Work Injury report with your employer?
Y N

Date of Injury:_____

Lawsuit planned /under consideration? Y N

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HEADACHE HISTORY FORM

Instructions:

- Answer each question the best you can.
- If the answer varies, give the answer that is most typical of your headaches.
- If you can't answer, or it doesn't apply, you may leave the question blank.

During the last 6 months, how many days of the month do you have a headache, *on average*? (circle a number)

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

During an average month, what percentage of your headaches are:
Severe: _____%
Moderate: _____%
Mild: _____%
Total: 100%

Are they increasing in:
Frequency? ☐Yes ☐No
Duration? ☐Yes ☐No
Severity? ☐Yes ☐No

How old were you when you first started having headaches? _____

Since you started getting headaches:
What is the longest you have had a continuous headache? _____
What is your longest headache-free period? _____

Was there a specific timeframe when your headache pattern changed? ☐Yes ☐No
If so, please explain: _____

Are you ever completely free of all pain in the head and the neck? ☐Yes ☐No

In the last **6 months** (if none, record as 0):
Days missed from Work due to headache _____
Days missed from Family/Social events due to headache _____
Trips to the Emergency Department due to headache _____

Have you ever been admitted to the Hospital for treatment of your headaches (longer than an ER visit?)
☐Yes ☐No _____

Have you ever sought treatment for your headaches at a National Center (e.g.: Mayo Clinic, Diamond Clinic, MHNI, Cleveland Clinic, Jefferson Clinic, etc) ☐Yes ☐No _____

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Have you ever had (in your life):

☐Whiplash ☐Concussion

☐Been in a motor vehicle accident ☐Had other trauma or surgery to your head or neck

Dental:

☐Frequent cavities/poor dentition ☐Frequent/significant dental work

☐Grind teeth ☐Trouble with the jaw: R / L / Both sides

Headache relief measures:

Please list all medications that you have taken over the last 6 months for headache relief. Include all over the counter medications or supplements, such as aspirin, ibuprofen, Tylenol, Excedrin, etc.

Effectiveness scale (-1 0 1 2):

-1 = made it worse **0** = no effect **1** = somewhat helpful **2** = very helpful

Rx	Frequency/week	Effectiveness
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2

Other relief measures?	Effectiveness
Ice	☐-1 ☐0 ☐1 ☐2
Heat	☐-1 ☐0 ☐1 ☐2
	☐-1 ☐0 ☐1 ☐2
	☐-1 ☐0 ☐1 ☐2
	☐-1 ☐0 ☐1 ☐2

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Additional treatments you have tried	Effectiveness
Chiropractic	☐-1 ☐0 ☐1 ☐2
Acupuncture	☐-1 ☐0 ☐1 ☐2
Biofeedback	☐-1 ☐0 ☐1 ☐2
Massage	☐-1 ☐0 ☐1 ☐2
Dry needling	☐-1 ☐0 ☐1 ☐2
Trigger point injections	☐-1 ☐0 ☐1 ☐2
Occipital nerve blocks	☐-1 ☐0 ☐1 ☐2
Botox	☐-1 ☐0 ☐1 ☐2
Pain blocks (facet injections, etc.)	☐-1 ☐0 ☐1 ☐2
Implanted stimulators	☐-1 ☐0 ☐1 ☐2
Dental Surgery	☐-1 ☐0 ☐1 ☐2
Sinus Surgery	☐-1 ☐0 ☐1 ☐2
TMJ Surgery	☐-1 ☐0 ☐1 ☐2
C-spine/Neck Surgery	☐-1 ☐0 ☐1 ☐2
Other:	☐-1 ☐0 ☐1 ☐2
Other:	☐-1 ☐0 ☐1 ☐2

Prior Testing

Below is a list of common tests/procedures that people often have. Please mark ALL that apply.

Testing	Year/Findings (normal/abnormal)
MRI Brain	
MRI Neck	
MR Angiogram	
MR Venogram	
CT Brain	
CT Sinuses	
CT Neck	
CT Angiogram	
CT Venogram	
Cervical Spine X-Rays	
Spinal Tap	
EEG (brain wave test)	
Sleep study (not in the home)	
Conventional Angiogram	
Carotid Artery Ultrasound (neck)	
Echocardiogram (heart)	

Testing	Year/Findings (normal/abnormal)
Tilt Table Test	
TMJ testing	
Electroconvulsive therapy (ECT)	
Neuropsychological Testing	

NOTES (Other things you wish us to know):

_____
_____
_____
_____
_____
_____

Thank you!

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HEADACHE DESCRIPTION FORM

Instructions:

- Answer each question the best you can.
- Mark all answers that apply to this headache type
- If the answer varies, give the answer that is most typical of your headaches.
- If you can't answer, or it doesn't apply, you may leave the question blank.
- ***If you have more than one type of headache,*** *then please fill out a separate Headache Description Form for each type.*

When did this headache pattern start? _____

Was there some event in your life that may have started this headache pattern? ☐Yes ☐No

If so, please explain: _____

_____

_____

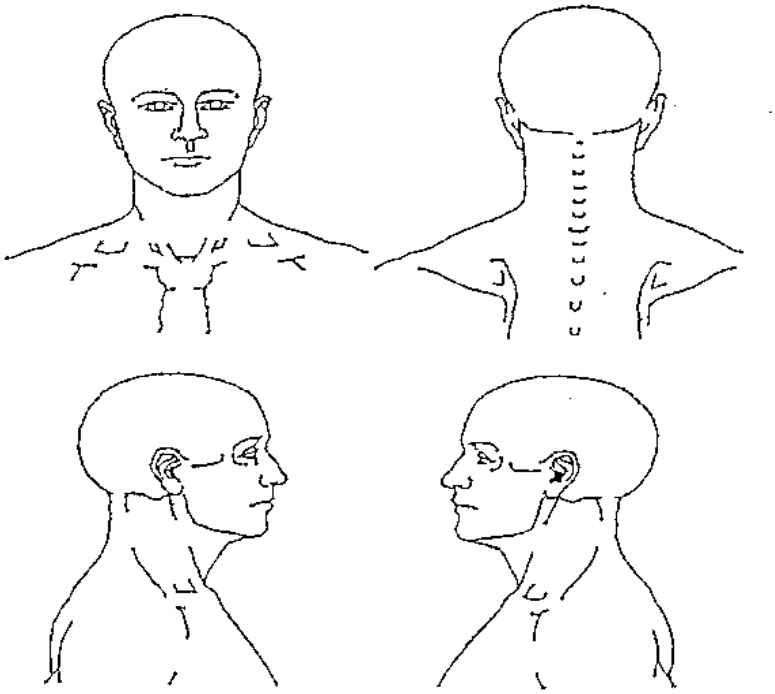
Do you get a warning sign before you get a headache?

☐Visual change ☐Fatigue ☐Ringing in the ears

☐Off balance ☐Sensory change ☐Localized weakness / numbness

☐Other: _____

Where does it start & where does it spread to? (please mark on the drawings)



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How painful does it typically get?

Pain Scale:
1 = mild/moderate pain, but can function normally
2 = moderate/severe pain, but still can do some things
3 = severe pain, have to stop/cannot function
4 = worst pain of your life/true agony

|_____|
1 2 3 4

How fast does it build, from no/minimal pain to its maximum pain level?

☐Seconds ☐Minutes ☐1hr ☐2-5hrs ☐6-12hrs
☐1day ☐2days ☐>2days ☐Varies/No Pattern

How long does it typically last, **without treatment?**

☐Seconds ☐Minutes ☐1hr ☐2-5hrs ☐6-12hrs
☐1day ☐2days ☐>2days ☐I don't know. I always treat it with something.

How long does it typically last, **with treatment?**

☐Seconds ☐Minutes ☐1hr ☐2-5hrs ☐6-12hrs
☐1day ☐2days ☐>2days

How do you treat your headache now (medications, other measures)?

_____
_____
_____

What does it feel like; how would you describe the pain?

☐Throbbing/pulsing ☐sharp/stabbing ☐burning/tingling
☐Pressure/squeezing ☐dull/nagging ☐jab/jolt
☐Other:_____

What time does your headache usually start?

|_____|
Midnight 6AM Noon 6PM Midnight
☐Unpredictable

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Associated Symptoms

During a headache, do you have any of these symptoms? (check ALL that apply)

☐Light sensitivity ☐Sound Sensitivity ☐Sensitivity to smells ☐Nausea
☐Vomiting

☐Blurred vision ☐Double vision ☐Zigzag lines ☐Tunnel vision
☐Blind spots ☐Bright spots ☐Colored spots

☐Pupil size change ☐Eyelid droop: Left/Right ☐Red/injected eye ☐Tearing
☐A feeling like there's something in the eye ☐Stuffy nose

☐Tingling/numbness; where?_____ ☐Weakness; where: _____
☐Jabs/jolts of pain ☐Vertigo/light headed/room spinning/sensation of movement
☐Falling ☐Ringing in the ears ☐Whooshing sound in the ears
☐Poor concentration ☐Confusion ☐Slurred speech
☐Passing out/Loss of consciousness ☐Seizures

☐Restlessness/can't hold still ☐Do you pace/rock?
☐Do you hit your head?

Headache triggers/Precipitating factors

Which of these things will set off this type of headache? (check ALL that apply)

☐Bright lights ☐Sun ☐Stress ☐Letdown
☐Weather changes ☐Change in sleep patterns ☐Allergies/Sinus
☐Hormonal changes: Menstrual period/ovulation/pregnancy/post-partum/contraceptives
☐Travel/time zone changes ☐Travel to Altitude ☐Fasting
☐Alcohol ☐Foods:_____ ☐Chewing/talking
☐Exercise / exertion ☐Position changes ☐Cough/strain ☐Orgasm
☐Flashing lights ☐Other:_____

NOTES (Other things you wish us to know):

_____
_____
_____
_____
_____
_____

Thank you!

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Medications

Please check the medications you have taken in the past

Analgesics				Anticonvulsants	
☐acetaminophen		☐Tylenol		☐carbamazepine	☐Tegretol
	---	☐Excedrin		☐gabapentin	☐Neurontin
	---	☐**Excedrin migraine**		☐lamotrigine	☐Lamictal
	---	☐Midol		☐levetiracetam	☐Keppra
	---	☐Goody Powder		☐oxcarbazepine	☐Trileptal
☐buprenorphine		☐Butrans		☐phenobarbital	☐Phenobarbital
☐butalbital		☐Fiorinal		☐phenytoin	☐Dilantin
	---	☐**Fioricet**		☐pregabalin	☐Lyrica
	---	☐Fioricet w/ codeine		☐primidone	☐Mysoline
	---	☐Esgic		☐topiramate	☐**Topamax**
	---	☐Phrenilin		☐valproate	☐**Depakote**
☐butorphanol		☐Stadol Spray		Antidepressants	
	---	☐Stadol Injection		☐**amitriptyline**	☐Elavil
☐codeine		☐222's		☐buproprion	☐Wellbutrin
☐fentanyl		☐Duragesic		☐buspirone	☐Buspar
	---	☐Actiq		☐citalopram	☐Celexa
☐hydrocodone		☐Vicodin		☐desvenlafaxine	☐Pristiq
☐hydromorphone		☐Dilaudid		☐doxepin	☐Sinequan
☐isometheptene		☐**Midrin**		---	☐Silenor
☐meperidine		☐Demerol		☐duloxetine	☐Cymbalta
☐methadone		☐Methadone		☐fluoxetine	☐Prozac
☐morphine		☐MS---IR		☐fluvoxamine	☐Luvox
	---	☐MS Contin		☐lithium	☐Eskalith
	---	☐Roxanol		☐mirtazapine	☐Remeron
☐nalbuphine		☐Nubain		☐nortriptyline	☐Pamelor
☐oxycodone		☐OXY---IR		☐paroxetine	☐Paxil
	---	☐Oxycontin		☐sertraline	☐Zoloft
	---	☐**Percocet**		☐trazodone	☐Desyrel
	---	☐Percodan		☐venlafaxine	☐Effexor
☐pentazocine		☐Talwin		Antihistamine/Decongestant	
☐propoxyphene		☐Darvon		☐cetirizine	☐Zyrtec
	---	☐Darvocet		☐chlorpheniramine	☐Chlortrimeton
☐tramadol		☐Ultram		☐cyproheptadine	☐**Periactin**
	---	☐Ultracet		☐dimenhydrinate	☐Dramamine
Angiotensin Receptor Blockers				☐diphenhydramine	☐Benadryl
☐candesartan		☐Atacand		☐fexofenadine	☐Allegra
☐losartan		☐Cozaar			

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Antihistamine/Decongestant (cont.)		Beta Blockers	
☐hydroxyzine	☐Vistaril	☐atenolol	☐Tenormin
---	☐Atarax	☐metoprolol	☐Lopressor
☐loratadine	☐Claritin	☐nadolol	☐Corgard
☐meclizine	☐Antivert	☐propranolol	☐**Inderal**
☐montelukast	☐Singulair	☐timolol	☐Blocadren
☐pseudoephedrine	☐Sudafed	Calcium Channel Blockers	
---	☐Drixoral	☐amlodipine	☐Norvasc
Anti---Inflamatory/NSAIDs		☐diltiazem	☐Cardizem
☐aspirin	☐Aspirin	☐nicardipine	☐Cardine
☐celecoxib	☐Celebrex	☐nifedipine	☐Procardia
☐**diclofenac**	☐Voltaren	☐**verapamil**	☐Calan
---	☐Cataflam	Ergotamines	
☐diclofenac powder	☐Cambia	☐dihydroergotamine	☐Migranal
☐ibuprofen	☐Motrin	☐ergotamine + caffeine	☐Cafergot
---	☐Advil	---	☐Wygraine
☐indomethacin	☐Indocin	☐methylergonovine	☐Methergine
☐ketorolac	☐Toradol tablets	☐methysergide	☐Sansert
---	☐**Toradol injections**	Hormonal Therapy	
☐nabumetone	☐Relafen	☐birth control pills	☐Seasonale
☐naproxen	☐Naprosyn	---	☐Seasonique
---	☐Aleve	---	☐Loestrin
---	☐Anaprox	---	☐Orthotricycline
☐rofecoxib	☐Vioxx	☐estrogen	☐Estrogen
☐sulindac	☐Clinorol	☐progesterone	☐Progesterone
☐valdecoxib	☐Bextra	MAOI	
Antipsychotics		☐phenelzine	☐Nardil
☐lithium	☐Eskalith	Muscle Relaxants	
☐olanzapine	☐Zyprexa	☐carisoprodol	☐**Soma**
☐perphenazine	☐Trilafon	☐chlorzoxazone	☐Parafon Forte
☐quetiapine	☐Seroquel	☐cyclobenzaprine	☐Flexeril
☐risperidone	☐Risperdal	☐lioresal	☐Baclofen
☐ziprasidone	☐Geodon	☐metaxalone	☐Skelaxin
Benzodiazepines		☐methocarbamol	☐Robaxin
☐alprazolam	☐**Xanax**	☐orphenadrine	☐Norflex
☐chlordiazepoxide	☐Librium	---	☐Norgesic
☐clonazepam	☐Klonopin	☐tizanidine	☐Zanaflex
☐clorazepate	☐Tranxene		
☐diazepam	☐Valium		
☐lorazepam	☐Ativan		
☐temazepam	☐Restoril		

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Phenothiazines		Triptans	
☐chlorpromazine	☐Thorazine	☐almotriptan	☐Axert
☐droperidol	☐Inapsine	☐eletriptan	☐Relpax
☐haloperidol	☐Haldol	☐frovatriptan	☐Frova
☐metoclopramide	☐Reglan	☐naratriptan	☐Amerge
☐prochlorperazine	☐Compazine	☐rizatriptan	☐Maxalt
☐promethazine	☐**Phenergan**	☐sumatriptan	☐**Imitrex**
☐thioridazine	☐Mellaril	---	☐Treximet
☐thiothixene	☐Navane	☐zolmitriptan	☐Zomig
☐trimethobenzamide	☐Tigan	Vitamins, Supplements, Herbal, Other	
Sleep/wake cycle		☐butterbur	
☐armodafinil	☐Nuvigil	☐coenzyme Q10	
☐chloral hydrate	☐Chloral Hydrate	☐feverfew	
☐dextroamphetamine	☐Dexadrine	☐magnesium	
---	☐Adderall	☐marijuana	☐Marinol
☐melatonin	☐Melatonin	☐migrelief	☐Migrelief
☐modafinil	☐Provigil	☐oxygen	
☐pemoline	☐Cylert	☐vitamin B2	☐**Riboflavin**
☐ramelteon	☐Rozerem	☐white willow	
☐zaleplon	☐Sonata		
☐zolpidem	☐Ambien		
Steroids			
☐dexamethasone	☐Decadron		
☐hydrocortisone	☐Solu---Cortef		
☐methylprednisolone	☐Solu---Medrol		
---	☐**Medrol Dosepak**		
☐prednisone	☐Prednisone		

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My Headache Diary

Name_____ **Month**_____

	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Pain Score:																															
Rescue Medication																															
1.																															
2.																															
3.																															
Relief?																															
Prevention Medication																															
1.																															
2.																															
3.																															
4.																															
5.																															
Menstrual Period (*)																															

Instructions:

What to do <u>Today</u>:	**When you have a headache**:
Fill in Your name The month Rescue medication list Prevention medication list	Find the appropriate date of the month. Choose your pain level (1-mild; 2-moderate; 3-severe) Indicate which *rescue medication* you used, if any (x) Indicate if the medication gave *relief* (0-no; 1-some; 2-yes) * for women, mark the days of your period