NASHVILLE NEUROSCIENCE GROUP | AdvancedHEALTH

www.NashvilleNeuroscience.com
eMail: nng.advancedhealth@NashvilleNeuroscience.com
2004 Hayes Street, Suite 650 | Nashville, TN 37203
P (615) 284-4680 **F** (615) 284-4681

NEW PATIENT INFORMATION PACKET

- ☐ Directions to the Office
- ☐ Physician / Facility Release
- ☐ Headache Assessment
- ☐ Patient Financial Policy
- ☐ General Consent for Treatment
- ☐ Patient Rights
- ☐ Patient Information Form
- ☐ Medical History
- ☐ PHQ-2 and PHQ-9 Screening
- ☐ Release of Medical Information
- ☐ Notice of Privacy Practices Acknowledgement
- ☐ Request for Medical Records

Completion of the New Patient Information Packet includes extensive patient medical history information which are very important in order to provide the most comprehensive and beneficial medical evaluation with the Nashville Neuroscience Group. These forms may be accessed on our website and may be completed on the website or downloaded for completion at your convenience. It is **EXTREMELY IMPORTANT** that these are completed and brought with you on the day of your appointment. If it is not convenient for you to access these from our website, we would be happy to provide you with a copy by e-mail or by regular mail at your request.

Please also bring your insurance cards, both primary and secondary if applicable. Your insurance company requires us to collect all Co-pays at check in.

If your insurance requires a referral from your primary care physician please make sure that this has been accomplished and that we have it by the time of your scheduled visit. We will be unable to complete your visit if the referral has not been secured.

It is very important that you give 24 hours notice if you are unable to keep your scheduled appointment with the Nashville Neuroscience Group. Cancellations that are not made 24 hours in advance will result in a missed appointment charge to you of $150, which will need to be paid before you can reschedule.

New patients who do not show for their appointments or who cancel on the same day of the appointment will not be rescheduled unless there are significant extenuating circumstances. **A non-refundable deposit may also be required to reschedule the appointment. This deposit may be applied to future appointments.**

If you have had brain or any other CT or MRI imaging within the past 2 years, please bring a copy of the report as well as any other records you may have.

Our providers want to ensure that all patients receive ample time to discuss their medical concerns and further treatment options. We ask that you allow 2-4 hours in our office for your first appointment, which may include video viewing, history taking, physical examination and possible research study participation.

PLEASE DO NOT wear cologne, scented lotions or perfumes to the office as these may cause migraine for our other patients.

Our front office staff would be happy to assist you with any questions you may have prior to your appointment. We can be reached at (615) 284-4680 or email us at nng.advancedhealth@nashvilleneuroscience.com

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DIRECTIONS TO THE OFFICE

From the North:
Take I- 65 South to I-40 West (Memphis)
Exit 84-A (Huntsville - Knoxville)
Exit onto Charlotte/Church Street
Turn RIGHT on Charlotte Avenue and continue to 19th Ave.
Turn LEFT on 19th Ave. and continue to Hayes Street.
Turn RIGHT at the stop sign on Hayes Street, drive two blocks then turn RIGHT into parking garage

From the South:
I-65 North to I-40 West
Exit on to Church St.
Turn LEFT on Church Street and continue on to 19th Ave., North
Turn LEFT on 19th Ave., North and continue to Hayes Street.
Turn RIGHT on Hayes Street, drive two blocks and then turn RIGHT into the parking garage.

From the East:
Take I-40 West into Nashville and exit onto Church Street
Turn LEFT on Church Street and continue to 19th Ave., North
Turn LEFT on 19th Ave., North and continue to Hayes Street
Turn RIGHT on Hayes Street, drive two blocks and then the RIGHT into the parking garage.

From the West:
Take I-40 East into Nashville and exit onto Charlotte/Church Street
Turn RIGHT on Charlotte Avenue and continue on to 19th Ave., North
Turn LEFT on 19th Ave., North and to continue to Hayes Street
Turn RIGHT on Hayes Street, drive two blocks and then turn RIGHT into the parking garage

From the Southeast:
Take I-24 East to I-40 West
Exit onto Church St.
Turn LEFT on Church Street and continue on to 19th Ave., North
Turn LEFT on 19th Ave. and continue to Hayes Street
Turn RIGHT on Hayes Street drive two blocks and then RIGHT into the parking garage

Valet Park or park inside the garage, then walk to or take the elevators to the garage 1st floor entrance. Enter building and take elevators in front to the 6th floor. Our office is located to the right off of the elevators in Suite 650.

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PATIENT INFORMATION FORM

Full Legal Name _____ Name Normally Used (Nickname) _____

Street address (not P.O. Box) _____ City _____ State _____ Zip Code _____

Mailing address (if different from above) _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

SSN _____ - _____ - _____ eMail _____ Date of Birth _____ / _____ / _____

Age _____ Sex _____ Race _____ Marital Status _____ Employer's Name _____

SPOUSE'S INFORMATION

Name _____ Date of Birth _____ / _____ / _____

Address (if different from above) _____ Occupation _____

Employer's Name _____ Employer's Address _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

INSURANCE INFORMATION

Responsible Party Name _____ Phone No ( ) _____

Responsible Party Address _____

Primary Insurance _____ Contract Holder's Name _____

SSN _____ - _____ - _____ Date of Birth _____ / _____ / _____ Relationship _____

Co-Pay $ _____ Contract No. _____ Group No. _____ Effective Date _____

Secondary Insurance _____ Contract Holder's Name _____

SSN _____ - _____ - _____ Date of Birth _____ / _____ / _____ Relationship _____

Co-Pay $ _____ Contract No. _____ Group No. _____ Effective Date _____

EMERGENCY CONTACT

Contact Name _____ Phone No ( ) _____

Primary Care Physician _____ Phone No ( ) _____

Referring Physician _____ Phone No ( ) _____

Pharmacy Name _____ Phone No ( ) _____

I hereby authorize Nashville Neuroscience Group, as a holder of medical information; to release to the referring physician, family physician or any medical or medically related facility, information regarding my diagnosis and treatment. I authorize Nashville Neuroscience Group to release to my insurance carrier or its intermediates, information needed for this or any future related claim(s). I further request payments be made to Nashville Neuroscience Group. I authorize application of credits generated from over payment to other open balances on my account.

Signature of Responsible Party _____ **Date** _____

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PHYSICIAN / FACILITY RELEASE FORM

Other physicians involved in my care include (for example, specialists in Obstetrics/Gynecology, Urology, Ophthalmology, Neurosurgery, Cardiology or others):

Doctor's Name:	Specialty:	Phone Number:	Fax Number:
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____
_____	_____	( ) _____	( ) _____

I hereby authorize Nashville Neuroscience Group, as a holder of medical information; to release to the referring physician, family physician or any medical or medically related facility, information regarding my diagnosis and treatment. I authorize Nashville Neuroscience Group to release to my insurance carrier or its intermediates, information needed for this or any future related claim(s). I further request payments be made to Nashville Neuroscience Group. I authorize application of credits generated from over payment to other open balances on my account.

I understand that I am financially responsible to Nashville Neuroscience Group for all services regardless of any portion page by my insurance carrier. I understand that 24 hour notification is required for cancellation of any return appointment or a fee of $50 will be charged to me. **I also understand that 24 hour notification is required for cancellation of my first "new patient" appointment or a fee of $150 will be charged to me. A non-refundable deposit may also be required to reschedule appointment. This deposit may be applied to future appointments.** I understand and agree to pay either fee should I fail to provide a minimum of 24 hours notice of cancellation before an appointment.

The Nashville Neuroscience Group reserves the right to refer unpaid past-due balances to third parties for collection. In the event that any past-due balance is placed with a third party, I agree to pay any costs of such collection including agency fees, legal/attorney fees, and court costs.

Because this is an outpatient neurology practice with limited staffing, we do not provide after hours or weekend care, including urgent/emergency care or inpatient hospital care. If you have a medical emergency after office hours or on the weekend, please go immediately to your local emergency room or call your primary care physician.

_____ _____

Signature of Patient Date

We invite you to discuss frankly with us any questions regarding our services or fees. The best medical service is based on friendly, mutual understanding between doctor and patient.

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Name _____ **DOB** _____

MEDICAL HISTORY

1. **Chief concern:** Briefly state the reason for your referral; we will gather more detailed information later.

_____

2. **Current Medications** (Please include all over-the-counter medications, oral contraceptives, estrogen replacement, nasal sprays and eye drops.)

Medication	Tablet Strength	How taken:

3. **Past Medical History**
Have you ever had any difficulty with these conditions (Check all that apply, and briefly explain: year diagnosed, treating MD, etc.):

- ☐ Thyroid disease: _____
- ☐ Diabetes: _____
- ☐ Heart Disease_____
- ☐ High cholesterol: _____
- ☐ Heart attack: _____
- ☐ High blood pressure: _____
- ☐ Headaches: _____
- ☐ Kidney disease: _____
- ☐ Kidney stones: _____
- ☐ Ulcers/GI disease: _____
- ☐ Lung disease: _____
- ☐ Rheumatologic disorder:_____
- ☐ Fibromyalgia: _____

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☐ Rheumatoid arthritis: _____

☐ Lupus: _____

☐ Psychiatric illness: _____

☐ Previous psychiatric hospitalization? _____

☐ Depression: _____

☐ Anxiety: _____

☐ Head injury: _____

☐ Seizure (If yes, list type of seizures, and date of last seizure): _____

☐ Meningitis:_____

☐ Encephalitis:_____

☐ Stroke:_____

4. **Allergies** **Reactions**

Medication: _____ _____

_____ _____

Foods: _____ _____

_____ _____

Substances: _____ _____

_____ _____

5. **Past Surgical History:**

Please list all surgeries including the year performed, and the surgeon if possible.

_____

_____

_____

_____

_____

_____

6. **Hospitalizations:**

Yes ☐ No ☐

Year _____ Hospital _____ Reason _____

Year _____ Hospital _____ Reason _____

Year _____ Hospital _____ Reason _____

Year _____ Hospital _____ Reason _____

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Name _____ **DOB** _____

7. Family History

How many siblings do you have? _____ Brothers _____ Sisters

Has anyone in your family had: If so, whom?

- ☐ Thyroid disease: _____
- ☐ Diabetes: _____
- ☐ Heart Disease_____
- ☐ Heart attack: _____
- ☐ Stroke: _____
- ☐ High blood pressure: _____
- ☐ Headaches: _____
- ☐ Cancer: _____
- ☐ Renal disease: _____
- ☐ Liver disease: _____
- ☐ Seizers: _____
- ☐ Psychiatric illness: _____

Mother's age: _____ Father's age: _____

If deceased, cause of death? Mother: _____ Father: _____

8. Social history:

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children (ages): _____

Occupation: _____ Spouse's occupation: _____

Hobbies: _____

Regular exercise: Type: _____ How often: _____

Do you use tobacco? ☐ Yes ☐ No How much per day? _____ For how many years? _____

Do you drink alcohol? (Type and frequency) _____

Illicit substance use: _____

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Name _____ **DOB** _____

9. Health Maintenance:

Last Pap Smear: _____ Results _____

Last Mammogram: _____ Results _____

Last Colonoscopy: _____ Results _____

Last Bone Densitometry: _____ Results _____

Covid 19 Vaccine: Yes ☐ No ☐ Date _____

Sexually active? Yes ☐ No ☐

Last Menstrual period? Date: _____ Are menses ☐ regular or ☐ irregular?

Birth control method: **(check all that apply)**

☐ Not sexually active

☐ Oral contraceptive – Name and Dosage: _____

☐ IUD (Intrauterine device)

☐ Implant – Name _____ Date of last implant _____

☐ Injection – Name _____ Date of last injection _____

☐ Condom

☐ Vasectomy Year _____

☐ Hysterectomy Year _____

☐ Menopause Year _____

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HEADACHE ASSESSMENT

This portion is for those patients who have concerns regarding headache.

1. Headache history:
   How many types of headache do you have? _____
   Please give a **brief** description of each type of headache: _____
   _____
   _____

2. Location:
   Headache starts: ☐ Left side ☐ Right side ☐ Either side ☐ All over ☐ Face/jaw ☐ Neck
   ☐ Other: _____

   Headache: ☐ Usually stays in one place ☐ Sometimes moves around
   ☐ Often moves around ☐ Other: _____

3. Description of pain: My headache pain is:

   ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Boring
   ☐ Pounding ☐ Pulsating ☐ Crushing ☐ Stabbing ☐ Squeezing
   ☐ Tight pressure or band-like (non-pulsating) ☐ Sharp ☐ Piercing
   ☐ Jabs or jolts (brief, repeated, continuous)

4. Severity: My headache pain is: (If there is more than one type of headache, check all that apply)

   ☐ Mild to moderate ☐ Severe ☐ Very severe ☐ Unbearable

   Headache prevents normal activities such as working? ☐ Yes ☐ No
   If yes: ☐ Rarely ☐ Occasionally ☐ Often ☐ Unable to work at all

5. Frequency:
   Headaches occur _____ times per ☐ Day ☐ Week ☐ Month ☐ Year
   Are they increasing in frequency or severity? ☐ Yes ☐ No
   How many headache free days do you have per week? _____ Per month? _____

6. Duration:
   My headache begins: ☐ In the morning ☐ In the afternoon ☐ At night ☐ Different times of the day
   and seem to last: ☐ Up to 4 hours ☐ Up to 8 hours ☐ Over 8 hours ☐ More than 24 hours ☐ Several days

7. At what age did your headaches begin? _____

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8. Prodrome: Premonition of headache that usually occurs within 24 hours before headache onset

☐ Food cravings ☐ Yawning ☐ Euphoria ☐ Mood swings ☐ Irritability ☐ Depression
☐ Fatigue ☐ Burst of energy

9. Aura: Do you experience any of these warnings before the headache begins? ☐ No ☐ Yes

☐ Flashing lights ☐ Dizziness ☐ Tingling or numbness in leg or arm ☐ Double vision
☐ Nausea/vomiting ☐ Ringing in the ears ☐ Blind spots ☐ Zigzag lines
☐ Decreased level of consciousness ☐ Weakness of a limb ☐ Decreased hearing
☐ Visual halos around objects ☐ Speech disturbance ☐ Incoordination

10. Symptoms that may accompany headache (check all that apply):

☐ Nausea/vomiting ☐ Swollen eyelid ☐ Light sensitivity ☐ Droopy eyelid
☐ Visual disturbance ☐ Sound sensitivity ☐ Nasal congestion ☐ Insomnia
☐ Constriction of pupil ☐ Change in hearing ☐ Facial swelling ☐ Dizziness
☐ Skin changes on face ☐ Neck pain/stiffness ☐ Eye redness ☐ Early morning awakening
☐ Numbness ☐ Other:_____

Hormonal (For women only):

11. Are your headaches made worse by: (Please check all that apply)

☐ Menstrual cycle ☐ Pregnancy ☐ Premenstrual period ☐ Ovulation
☐ Birth control pills ☐ Menopause ☐ Hormone replacement therapy

Age at first menstrual cycle _____ Headaches started then? ☐ Yes ☐ No

Age at first oral contraceptives _____ Headaches ☐ worse ☐ better ☐ unchanged

Age at first hormone replacement therapy _____ Headaches ☐ worse ☐ better ☐ unchanged

Hysterectomy? ☐ No ☐ Yes If yes, with ovaries removed? ☐ Yes ☐ No

Age or Year _____ Headaches ☐ worse ☐ better ☐ unchanged

12. Is your overall condition:

☐ Staying the same ☐ Worsening ☐ Improving ☐ Affecting daily activities

13. Seasonality:

Headaches are most frequent in: ☐ Winter ☐ Spring ☐ Summer ☐ Autumn ☐ Non-seasonal

14. Things that alleviate your headaches:

☐ Cold ☐ Dark room ☐ Exercise ☐ External pressure ☐ Heat ☐ Ice
☐ Medication ☐ Rest ☐ Sleep ☐ Stress reduction ☐ Chiropractic ☐ Massage
☐ Biofeedback ☐ Acupuncture ☐ Other _____

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15. Aggravating Factors:

Headaches can be brought on by: (Please check all that apply)

☐ Fatigue ☐ Oversleeping ☐ Certain medications ☐ Coughing ☐ Exercise
☐ Lying down ☐ Under sleeping ☐ Exertion ☐ Loud noise ☐ Missing a meal
☐ Changes in weather ☐ Stress ☐ Bright light ☐ Relief from stress
☐ Hormonal changes ☐ Shaving/touching face ☐ Chewing or talking
☐ Odors (list): _____
☐ Foods (list): _____
☐ Alcohol (list): _____
☐ Other (list): _____

16. Caffeine use:

☐ Coffee _____ cups/day
☐ Tea _____ cups/day
☐ Soda _____ bottles/cans per day

Does caffeine seem to have any effect on your headache? ☐ Yes ☐ No ☐ Sometimes

17. How much water do you drink per day:

☐ None ☐ 1 bottle (16 oz) or less ☐ 1-2 bottles (16-32 oz) ☐ 3-4 bottles (48-64 oz)
☐ 4-5 bottles (64-80 oz) ☐ 5-6 bottles (80-96 oz) ☐ more than 6 bottles (over 96 oz)

18. How many meals do you eat per day: _____ breakfast/lunch/dinner

Protein with each meal? (dairy, egg, meat, nuts, vegetable protein such as soy) ☐ Yes ☐ No

19. How well do you sleep?

☐ I usually sleep well ☐ My sleep difficulty is most often with _____ initiating, or _____ maintaining sleep
☐ I sometimes have trouble sleeping ☐ I often have trouble sleeping ☐ I always have trouble sleeping

What time of day do you usually go to bed? _____
What time of day do you usually get up? _____
Do you nap during the day? ☐ Yes ☐ No Do you feel refreshed after sleeping overnight? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No Do you have restless leg movements? ☐ Yes ☐ No
Do you sometimes struggle to breathe at night? ☐ Yes ☐ No

20. Any previous head injuries – concussion, skull fracture, bleed? ☐ No ☐ Yes, describe _____

_____

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21. **ALL PATIENTS:** Review the list of medications below. Select any that you have tried in the past, **write down the dose if you can remember it, the side effects and whether or not it was effective.**

PREVENTIVE MEDICATIONS	Helpful?	Side Effects?	Dosage	ABORTIVE MEDICATONS	Helpful?	Side Effects?	Dosage
☐ Verapamil/Calan	☐ Yes ☐ No	☐ Yes ☐ No		☐ Cafergot	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Candesartan/Atacand	☐ Yes ☐ No	☐ Yes ☐ No		☐ Fiorinal/Butalbital+Aspirin	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Magnesium	☐ Yes ☐ No	☐ Yes ☐ No		☐ Midrin/Prodrin	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Riboflavin	☐ Yes ☐ No	☐ Yes ☐ No		☐ Anaprox(Naprosyn)	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Feverfew	☐ Yes ☐ No	☐ Yes ☐ No		☐ CBD Oil	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Prozac/Fluoxetine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Cambia/Diclofenac	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Paxil/Paroxetine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Zipsor/Diclofenac	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Zoloft/Sertraline	☐ Yes ☐ No	☐ Yes ☐ No		☐ Toradol/Ketoralac	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Celexa/Citalopram	☐ Yes ☐ No	☐ Yes ☐ No		☐ Steroids/Cortisone	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Lexapro/Escitalopram	☐ Yes ☐ No	☐ Yes ☐ No		☐ Stadol/Butorphanol	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Effexor/Venlafaxine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Lortab/Norco/Hydrocodone	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Cymbalta/Duloxetine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Ultram/Tramadol	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Elavil/Amitriptyline	☐ Yes ☐ No	☐ Yes ☐ No		☐ Percocet/Oxycodone	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Pamelor/Nortriptyline	☐ Yes ☐ No	☐ Yes ☐ No		☐ Mepergan/Demerol	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Tegretol/Carbamazepine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Imitrex/Sumatriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Trileptal/Oxcarbazepine	☐ Yes ☐ No	☐ Yes ☐ No		☐ Maxalt/Rizatriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Neurontin/Gabapentin	☐ Yes ☐ No	☐ Yes ☐ No		☐ Zomig/Zolmitriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Lyrica/Pregabalin	☐ Yes ☐ No	☐ Yes ☐ No		☐ Amerge/Naratriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Zonegran/Zonisamide	☐ Yes ☐ No	☐ Yes ☐ No		☐ Axert/Almotriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Inderal/Propranolol	☐ Yes ☐ No	☐ Yes ☐ No		☐ Frova/Frovatriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Toprol/Metoprolol	☐ Yes ☐ No	☐ Yes ☐ No		☐ Relpax/Eletriptan	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Kerlone/Betaxolol	☐ Yes ☐ No	☐ Yes ☐ No		☐ Treximet/Sumatriptan+Naproxen	☐ Yes ☐ No	☐ Yes ☐ No	

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PREVENTIVE MEDICATIONS	Helpful?	Side Effects?	Dosage	ABORTIVE MEDICATONS	Helpful?	Side Effects?	Dosage
☐ Corgard/Nadolol	☐ Yes ☐ No	☐ Yes ☐ No		☐ DHE - Ergotamine	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Tenormin/Atenolol	☐ Yes ☐ No	☐ Yes ☐ No		☐ Migranal/DHEA	☐ Yes ☐ No	☐ Yes ☐ No	
☐ BOTOX	☐ Yes ☐ No	☐ Yes ☐ No		☐ Fioricet/Butalbital+Tylenol	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Wellbutrin/Buprpoprion	☐ Yes ☐ No	☐ Yes ☐ No		☐ Periactin/Cyproheptadine	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Depakote/Divalproex	☐ Yes ☐ No	☐ Yes ☐ No		☐ Ubrelvy	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Topamax/Topiramate	☐ Yes ☐ No	☐ Yes ☐ No		☐ Reyvow	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Keppra/Levitiracetam	☐ Yes ☐ No	☐ Yes ☐ No		☐ Nurtec	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Lamictal/Lamotrigine	☐ Yes ☐ No	☐ Yes ☐ No		**Additional information:**			
☐ Aimovig/Ajovy/Emgality/ Vyepti	☐ Yes ☐ No	☐ Yes ☐ No					
☐ Other Medications tried, not listed	☐ Yes ☐ No	☐ Yes ☐ No					

22. Previous Headache evaluation. What diagnostic tests for headache have you had in the past?

☐ CT scan ☐ MRI scan ☐ Sinus x-ray ☐ EKG ☐ Lumbar puncture

☐ Neuropsychiatric testing ☐ Other: _____

Where was testing done? _____

Previous headache treatment: (Include as much as you can recall, previous medical records or pharmacy printouts may be helpful. Use the next page also if several medications have been tried.) This information on medications tried will be very helpful.

Year Seen	Doctor's Name	Specialty / Treatment Provided	Results

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23. MIDAS Score _____

The Migraine Disability Assessment Test

The MIDAS (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your head-aches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS:

Please answer the following questions about **ALL of the headaches** you have had over the last 3 months. Write your answer in the box next to each question. **Write zero** if you did not have the activity in the last 3 months.

_____ 1. On how many days in the last 3 months did you miss work or school because of your headaches?

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

_____ 3. On how many days in the last 3 months did you **not do household work** (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

_____ 4. How many days in the last 3 months was your productivity in household work **reduced by half of more** because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

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

_____ Total (Questions 1-5)

24. Family history: What family members have headache?

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal Grandparents

☐ Paternal Grandparents ☐ Children ☐ Others: _____

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REVIEW OF SYMPTOMS (Mark any of the following complaints you currently have):

NEURO

☐ Dizziness

☐ Fainting / Blackouts

☐ Forgetfulness

☐ Headache

☐ Balance Trouble

☐ Pain
Where? _____
_____

☐ Weakness
Where? _____
_____

☐ Numbness
Where? _____
_____

HEME / SKIN

☐ Anemia

☐ Sores that won't heal

☐ Easy Bruising

ENDOCRINE

☐ Heat / Cold Tolerance

☐ Diabetes

☐ Thyroid Problems

☐ Abnormal Sweating

GASTROINTESTINAL

☐ Poor Appetite

☐ Bowel Changes

☐ Nausea

☐ Stomach Pain

☐ Vomiting

GENERAL

☐ Change In weight

☐ Snoring

☐ Fevers

☐ Restless Arms / Legs

☐ Fatigue

☐ Daytime Sleepiness

PSYCHIATRIC

☐ Psychiatric Care

☐ Suicide Attempt

☐ Chemical Dependency

☐ Depression

☐ Anxiety

CARDIOVASCULAR

☐ Pacemaker

☐ Chest Pain

☐ High Blood Pressure

☐ Low Blood Pressure

☐ Varicose Veins

RESPIRATION

☐ Shortness of Breath

☐ Frequent Cough

☐ Asthma

☐ Emphysema / COPD

MALE / FEMALE

☐ Erectile Dysfunction

☐ Miscarriages

☐ Currently Pregnant?

EAR, NOSE, EYE, THROAT

☐ Blurred Vision

☐ Spot / Floaters

☐ Diff. Swallow

☐ Double Vision

☐ Strange Odor

☐ Taste Change

☐ Hearing Loss

☐ Loss of Speech

☐ Ringing Ears

☐ Sinus Problems

URINARY

☐ Lack of Bladder Control

☐ Painful Urination

☐ Kidney Stones

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PHQ-2 AND PHQ-9 DEPRESSON SCREENING

Name _____ Birthdate _____ / _____ / _____ Today's Date _____

Part of routine screening for your health includes reviewing mood and emotional concerns.
During the past two weeks, have you often been bothered by of the following problems?

Feeling down, depressed, irritable or hopeless? ☐ Yes ☐ No

Little interest or pleasure in doing things? ☐ Yes ☐ No

If you answered "Yes" to either question above, please answer all questions below.

During the past two weeks, How often have you been bothered by the following problems?	**(0) Not At All**	**(1) Several Days**	**(2) More than Half the Days**	**(3) Nearly Every Day**
Feeling down, depressed, irritable or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss, or overeating				
Feeling tired or having little energy				
Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, like reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

For Office Use Only: Total Score