

New York Headache Center

NYHeadache.com

Patient Information

Date _____ Date of birth _____ Place of birth _____

Name _____ Marital status _____

Sex assigned at birth: Male Female Gender identity _____

Address _____

Phones: Cell _____ Home _____ Work _____

e-mail _____

SS # *(can be provided in the office)* _____ Occupation _____

Employer _____

Insurance _____

In case of emergency contact:

Name _____ Relationship _____ Phone _____

Name and phone number of the pharmacy you use _____

Referring physician _____

Street address/phone _____

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

Referred by (friend, media, etc.) _____

Reason for this visit

Please obtain and forward to us your medical records, including recent blood test results, CT, and MRI scans.
Email the results and this form to admin@nyheadache.com or fax to 212-794-0591 or mail ahead of your visit.

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

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

When was your last headache: _____

Are you ever free of pain completely? Yes ☐ No ☐ Do you have more than one type of headaches? Yes ☐ No ☐

If yes, describe them separately:

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

How would you describe the pain of your most serious headaches:

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

vise-like ☐ hot ☐ burning ☐ sickening ☐ blinding ☐ unbearable ☐ punishing ☐ vicious ☐ exhausting ☐

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

Are your headaches brought on by:

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

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

certain foods _____ other _____

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

Do you have any visual or other symptoms before the start of a headache: ☐ Yes ☐ No

Describe: _____

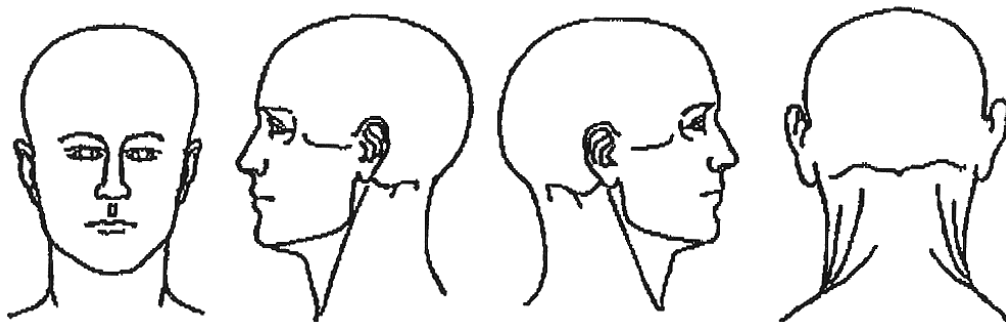
Checkmark any of the following symptoms you have with your headaches:

Neck pain ☐ Nausea ☐ Vomiting ☐ Light sensitivity ☐ Noise sensitivity ☐ Smell sensitivity ☐ Dizziness ☐

Numbness ☐ Weakness ☐ Confusion ☐ Difficulty speaking ☐ Tearing ☐ Nasal congestion ☐ Eyelid drooping ☐

Worsening of pain with movement ☐ Other: _____

Please indicate with x's where you experience pain



Have you seen a doctor for your headaches: an eye doctor ☐ an ear-nose-throat specialist ☐ a TMJ dentist ☐ other _____

Describe tests you've had for your headaches (get us copies if you can) _____

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

Aimovig / erenumab	Desyrel / trazodone	Methergine / methylergonovine	Sprix / ketorolac
Ajovy / fremanezumab	Diamox / acetazolamide	Migranal / dihydroergotamine	Symbravo / riza w/meloxicam
Advil / ibuprofen	Dilaudid / hydromorphone	Mobic / meloxicam	Topamax / topiramate
Aleve / naproxen	Effexor / venlafaxine	Motrin / ibuprofen	Toprol / metoprolol
Amerge / naratriptan	Elavil / amitriptyline	Low-dose-naltrexone	Toradol / ketorolac
Aspirin	Emgality / galcanezumab	Namenda / memantine	Trintellix / vortioxetine
Atacand / candesartan	Excedrin	Nardil / phenelzine	Tylenol / acetaminophen
Ativan / lorazepam	Fioricet / butalbital	Neurontin / gabapentin	Ubrelyvy / ubrogepant
Axert / almotriptan	Fiorinal / butalbital	Norpramine / desipramine	Ultram / tramadol
Benicar / olmesartan	Flexeril / cyclobenzaprine	Nurtec / rimegepant	Valium / diazepam
Botox	Frova / frovatriptan	Pamelor / nortriptyline	Vicodin / hydrocodone
Bystolic / nebivolol	Imitrex / sumatriptan	Percocet / oxycodone	Vivactyl / protriptyline
Cafergot / ergotamine	Inderal / propranolol	Periactin / cyproheptadine	Voltaren / diclofenac
Calan / verapamil	Indocin / indomethacin	Phenergan / promethazine	Vyepti / eptinezumab
Cambia / diclofenac	Journavx / suzetrigine	Prednisone	Xanax / alprazolam
Celebrex / celecoxib	Keppra / levetiracetam	Pristiq / desvenlafaxine	Zanafex / tizanidine
Cymbalta / duloxetine	Klonopin / clonazepam	Prozac / fluoxetine	Zavzpret / zavegepant
Codeine	Lamictal / lamotrigine	Qulipta / atogepant	Zofran / ondansetron
Compazine / prochlorperazine	Lithium	Reglan / metoclopramide	Zoloft / sertraline
Decadron / dexamethasone	Lyrica / pregabalin	Relpax / eletriptan	Zomig / zolmitriptan
Decongestants	Maxalt / rizatriptan	Relafen / nabumetone	Zonegran / zonisamide
DHE-45 / dihydroergotamine	Marijuana	Remeron / mirtazapine	Other
Depakote / divalproex	Medrol / methylprednisolone	Savella / milnacipran	

* Star those which helped, even for a while.

Are you or your partner currently planning a pregnancy or trying to conceive? Yes No

Have you tried any of the following treatments:

Acupuncture ☐ Biofeedback ☐ Meditation ☐ Chiropractic ☐ Physical therapy ☐ Other _____

Magnesium ☐ Riboflavin (vitamin B2) ☐ CoQ10 ☐ Feverfew ☐ Butterbur ☐ Boswellia ☐ Other _____

Gluten-free ☐ Dairy-free ☐ Vegetarian ☐ Keto ☐ Other diets _____

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

—	—	—
—	—	—
—	—	—
—	—	—

List all other medicines you are taking and indicate the reason:

—	—	—
—	—	—
—	—	—
—	—	—

Midas Questionnaire | Migraine Disability Assessment

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

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

1. On how many days in the last 3 months did you miss work or school because of your headaches?
(If you do not attend work or school enter zero in the space to the right.) .
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend school or work enter zero at right.) .
3. On how many days in the last 3 months did you not do household work because of your headaches?
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend school or work enter zero at right.) .
5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?
- A. On how many days in the last 3 months did you have a headache
(If headache lasted more than 1 day, count each day.).
- B. On a scale of 0-10, on average, how painful were these headache
(Where 0=no pain at all, and 10=pain which is as bad as it can be.).

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

During the past month

- | | | |
|---|-----|----|
| 1. Have you been bothered a lot in the last month by feeling sad, down, or depressed? | Yes | No |
| 2. Have you been bothered a lot in the last month by a loss of interest or pleasure in your daily activities? | Yes | No |

For men: When was the last time you had more than five drinks in one day?

Never In the past three months Over three months ago

For women: When was the last time you had more than four drinks in one day?

Never In the past three months Over three months ago

Have you suffered a traumatic event (car accident, major injury or illness, physical, emotional, or sexual abuse)?	Yes	No
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If yes, in the past month:

- | | | |
|--|-----|----|
| 1. Have you had nightmares or unwanted thoughts about the event? | Yes | No |
| 2. Do you try to avoid reminders of it? | Yes | No |
| 3. Are you constantly on guard or easily startled? | Yes | No |
| 4. Do you feel numb or detached from people or activities? | Yes | No |
| 5. Do you feel guilty or blame yourself for the event? | Yes | No |

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

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

Comments:

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

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

Please list your allergies, if any _____

What is your height _____ Weight _____ Ethnicity _____

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

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

What time do you go to sleep and wake up? Weekdays _____ Weekends _____

Physical exercise/frequency/duration: _____

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

If you have children, please list their ages: _____

Please list hobbies/recreational activities: _____

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

Level of education: _____ Do you have pets: _____

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

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

Is there a family history of (please check):

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

Financial Responsibility

In order for us to provide best possible care we would like to explain the details of reimbursement.

Services Provided by Nurse Practitioners

Services provided by a Nurse Practitioner are billed under an M.D. on our staff who is contracted with your insurance carrier, so please do not be surprised if you see a bill with the name of a doctor whom you have not seen. This is called "Incident-to Billing".

Late cancellation and no show fees

If you are unable to keep your appointment, please call the office as soon as you can and at least 24 hours before the appointment. There will be a no show/late cancellation fee of \$75 if you do not cancel and don't keep your appointment.

Insurance Coverage

It is your responsibility to be familiar with your insurance coverage, policy provisions, exclusions and limitations. This information is obtained by contacting your insurance carrier. We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for payment is yours. If you have had any changes in your insurance coverage, even if there is only a small change in the copayment amount or a change in the expiration date of the policy, you need to notify us. Even a small discrepancy on the claim form can lead to a claim denial, leaving you responsible for the entire payment.

Co-Payments, Co-Insurance and Deductibles

Co-payments (usually a flat fee) and co-insurance (typically a percentage of the cost) must be paid at the time of the visit. Our failure to collect these fees is considered a form of insurance fraud. You are also responsible for payment of your yearly deductible. The deductible amount is determined by your individual contract with the insurance carrier. It is your responsibility to know your specific deductible amount and how much of that has been met by the time of your visit.

Referrals/Authorizations

Many insurance carriers require pre-authorization and/or a referral for each visit with us. You are responsible for obtaining these referrals or authorizations. Please contact your insurance carrier if you have any questions regarding these requirements.

By signing below, I have read and fully understand this form. I acknowledge my financial responsibility and I consent to continue with treatment.

Patient's name (printed)

Patient's Signature

Date

Information Release

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

Patient's name (printed)

Patient's Signature

Date

HIPAA Notice of Privacy Practice

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

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

1. Uses and Disclosures of Protected Health Information

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

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

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

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

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

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

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

Your Rights

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

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

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

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

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

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

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

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

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

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

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

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

PATIENT NAME _____

PATIENT'S SIGNATURE _____

DATE ____ / ____ / ____