Faculty Practice Plan
Waiver of Coverage Form: *Responsibility for non-covered services*

**I. Financial Responsibility**

I acknowledge full financial responsibility for services rendered by **Dr. _____** or physicians providing medical coverage in his/her behalf. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and copayments. I understand payment of copays is expected at time of service as well as any other balances I may owe. Furthermore, I understand that I am responsible for payment of any non-covered service and to bring a referral if the services I receive require one from my insurance carrier. I am responsible for payment of any services received without a referral or proper authorization.

**II. Assignment of Benefit Proceeds**

I consent that the payment of third party payers from my insurer, HMO, or other third party payer, be made on my behalf directly to my physician.

**III. Authorization of Release of Records**

I hereby authorize **Dr** _____ to release my insurer/HMO/third party payer, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care, if required, for pre-certification and/or prior approval purposes.
It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services which are not medically necessary or improperly billed.

**Signature of Patient or Authorized Representative** **Date**

**Witness** **Date**

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

# PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI can be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

**Home telephone :**

- ☐ **OK to leave msg with detailed information**
- ☐ **Leave msg with call back number only**
- ☐ **Do not call or leave msg**

**Cell phone number:**

- ☐ **OK to leave msg with detailed information**
- ☐ **Leave msg with call back number only**
- ☐ **Do not call or leave msg**

**Email:**

- ☐ ***Per Physician preference**

*SEE PAGE 2 FOR ADDITIONAL AUTHORIZATION*

**Written communication:**

- ☐ **OK to mail to my home address**
- ☐ **OK to mail to my office/work address**
- ☐ **Do not mail to my home or office**

**Work telephone:**

- ☐ **OK to leave msg with detailed information**
- ☐ **Leave msg with call back number only**
- ☐ **Do not call or leave a msg**

**Other:**

_____

_____

_____ _____

**Print Name** **Date**

_____ _____

Patient Signature Date

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

**NOTE:** Uses and disclosures for TPO may be permitted without prior consent in an emergency.

**Authorization to discuss health information:**

**By initialing here _____**

**I authorize Dr. _____to discuss my health information with_____**

***Record of disclosures of Protected Health Information**

Name: _____ DOB: _____/_____/_____

# GUIDELINES FOR MEDICATION AND DRUG SCREENING

**Patient Name** **DOB** **Today's Date**

I will be seen at the Neuroscience Institutes of Great Neck, Physician Partners, Northwell Health, Pain and Headache Treatment Center for relief of my pain. I understand that my treating clinician often used medications trials to help reduce the intensity and frequency of pain. This therapeutic modality is often considered as one component of a comprehensive pain management program. ***Please initial each line as indicated.***

## PART 1 Informed Consent

_____ 1. I have been informed of the risk of developing tolerance, or an addiction to opioid dependency, and also of the risk of addiction to any newborn children of pregnant female patients taking opioids. I have been informed of the risk of depression and suicidal ideation from narcotics.

_____ 2. I give permission to the office of the prescribing physician to contact my pharmacy and/or my other physicians directly, at the physician's discretion, to discuss, review and evaluate my prescription and medical data.

_____ 3. Please be advised upon conclusions of your 1st visit we reserve the right to contact previous treating physicians and pharmacies; therefore you may not receive any controlled substance medications at your first visit.

## PART 2 Long Term Medication Agreement

**Our policy regarding the use of prescription medication at the center:** I agree to the following,

_____ 1. I will not exceed the prescribed dose unless cleared in advance by the Physician

_____ 2. I will not have other practitioners provide pain medicine unless cleared in advance by my Pain Management clinician

_____ 3. I will provide my pain management clinician with a list of all ongoing current medications prescribed by other practitioners as well as over the counter medications including vitamins and herbs. I give my physician permission to speak with my pharmacist and/or treating clinicians in regard to my care

_____ 4. A single pharmacy will provide the medication. At the beginning of this agreement you must designate the name of that pharmacy and it cannot be changed, except in writing with reasonable notice.

_____ 5. I will notify my physician within 24 hours if additional controlled medications are prescribed to you by any other health care provider. (e.g, by emergency room, the hospital or other physicians)

_____ 6. Under **no circumstance** are you to share, distribute, exchange medication prescribed to you.

_____ 7. The decision to drive is your responsibility, as you have been made aware that opioids can partially affect your driving ability.

Northwell Health
Physician Partners

# GUIDELINES CONTINUED

**PART 3 Our policy regarding the use of "controlled" substances at the center:**
Examples include but are not limited to Vicodin, Percocet, MS Contin, Oxycontin, Duragesic, Dilaudid, Methadone or anti-Anxiety medication. I agree that:

_____ 1. Controlled substance prescriptions will be provided ***only*** in person and ***only*** at the time of my scheduled visit unless cleared by clinician

_____ 2. Controlled substance prescriptions will not be mailed or called into a pharmacy unless cleared by our clinician. Please allow up to 3 business days for your prescription to be called in.

_____ 3. It is my responsibility to make monthly follow up appointments after each visit unless cleared by my clinician

_____ 4. I am responsible to store my medications either in a locked box or safe.

**PART 4 Our policy regarding prescriptions for 'non-controlled' substances at the center:**
Examples include, but are not limited to anti-depressants, anti-consultants, muscle relaxants, and anti-inflammatories. I agree that

_____ 1. **Please allow up to 3 business days** (from the time of my phone call to the center) for all non-controlled substances to be called into the pharmacy.

**PART 5 Our policy regarding intermittent Urine Drug Screening**

_____ 1. Your physician reserves the right to perform intermittent or unannounced urine drug testing. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the Doctor-patient relationship.

_____ 2. I will submit to intermittent urine screening upon request of the pain clinician

**Please be aware, these guidelines are in place to help provide the best care to our patients.**
**By signing below, I agree that I have read and understand these guidelines.**
**Failure to comply with these guidelines may result in the discontinuation of prescribing such medication(s) at the center.**
**In addition, failure to comply with the guidelines may result in dismissal from our practice.**

_____

Signature of Patient Date

_____

Signature of Physician Date

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

## What is a *formulary*?

If you have prescription coverage for the medication your clinician prescribes, you will want to become familiar with your insurance carriers drug pricing system called a *formulary*. The formulary will contain approved medications by the insurance carrier. The list was created to keep cost down for the insurance company while offering you a competitive list of drug options.

## How does this affect our patients?

Your insurance carrier may not cover part or all of the cost for medication your clinician prescribes. Requesting the *formulary* and reviewing it with your clinician during your office visit will ensure you find the right treatment options for the least out of pocket expense.

## What if I need a non-*formulary* drug?

If you agree that a non-*formulary* drug is the best option, you will have to work with your Doctor to get an approval from your insurance company. This is called an exception process and can delay you receiving your medication.

## How do I obtain a *formulary*?

Any Healthcare payer will make its *formulary* available to you. It will be readily available on its website or contact the customer service department and they will mail it to you.

I have read and understood the need for a *formulary.*

**Signature of Patient or Authorized Representative** **Date**

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

**Northwell Health Physician Partners Pain & Headache Center Patient Self Report Form**

**Patient Demographics:**

Name: _____ Birthdate: _____/_____/_____ Age: _____

Referred by: †primary care physician †other neurologist †family member
†friend †other (please write) _____
Name of referring person: _____
Family Physician or Primary Care: _____ Phone #: _____
Address: _____
_____
City: _____ State: _____ Zip: _____

**Headache History:**

Describe your problem? _____
_____
_____
_____
_____
Are you involved in any lawsuits regarding this problem?†Yes †No (describe) _____
Do you have more than one headache type? †Yes †No
Describe headache type #1: _____
Describe headache type #2: _____
Are you ever headache free? †Yes †No
When? †Pregnancy †Vacation †Weekends †Random †Remission
†Other (describe) _____
Onset of initial headache:
Headaches started _____ years ago I was _____ years old

Northwell Health
Physician Partners

# Patient Self Report Form

**Headache Type #1:**

Date of onset of first headache type: _____

Precipitating Event (what provoked your first headache):
†None known †Injury (describe) _____
†Menarche (1st Menstrual Period) †Pregnancy
†Other (describe) _____
Pattern of Onset: †Sudden †Rapid †Gradual †Varies
Timing of headache: † Morning †Afternoon † Evening †Night
† Awakens from sleep Varies
Periods of increased frequency: †Weekends †Weekdays †Vacation
†Seasonal (Spring/ Summer/ Fall/ Winter)
Frequency of attacks: # per day † # per week† # per month†
# per year† # of lifetime attacks †continuous†
Are they increasing in frequency? †Yes †No
Duration: (How long do they last?)
With medication lasts: _____minutes _____hours†_____days
How often does it recur within 24 hours? ___% of time
Without medication lasts: _____minutes _____hours†_____days
How often does it recur within 24 hours? ___% of time
Severity: (How bad is the pain on a scale from 0 to 10 <where 0 is no pain and 10 is the worst>)
Lowest and highest level of pain for this headache type:
Low _____ High _____

Usual severity of this headache type: _____
Worse with menses? †Yes †No

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

Allodynia:

Do you experience pain or unpleasant sensation *on your skin* during an attack when you:

| | | | | | |
|---|---|---|---|---|---|
| Comb your hair | †Yes | †No | Pull your hair back | †Yes | †No |
| Shave | †Yes | †No | Wear glasses | †Yes | †No |
| Wear contacts | †Yes | †No | Wear earrings | †Yes | †No |
| Wear necklaces | †Yes | †No | Take a shower | †Yes | †No |
| Expose to heat/ cold | †Yes | †No | Rest head on pillow | †Yes | †No |

Location: †Temples †Back of Head †Side of Head †Front of Head
†Around Head †Eye † Ear † Neck
†Jaw † Other (describe)_____

Sidedness: †Left-sided †Right-sided
†Both sides †Varies

Change sides: †Between attacks †During attacks †Both between and during

Character: †Throbbing/ Pulsing †Pressure †Achy
†Burning Tight † Searing
†Dull †Shooting †Stabbing
†Other (describe) _____

Activities that worsens headache: †None †Walking
†Climbing steps †Exercise
†Other (describe) _____

Headache disability during or immediately after an attack:
†Normal activity †Slight decrease in function
†Moderate decrease in function †Severe decrease in function
†Confined to bed

Associated features: †Nausea †Vomiting
†Light Sensitive †Sound Sensitive †Smell Sensitive
†Diarrhea †Constipation † Insomnia
†Increased Urination † Increased appetite †Decreased appetite
†Sore/ stiff neck †Ringing in ears †Blurred vision
†Eye Tearing (R/L/B) † Anxiety †Poor concentration
†Nose Congested (R/L/B) †Irritability † Memory Problems
†Drooping Eyelid (R/L/B) †Confusion †Change in Pupil
†Language difficulty † Visual spotting †Skin sensitivity
†Other (describe) _____

Aura: Do you have any of these symptoms before your headache begins? (Check all that apply)

Visual

†Blurry vision †Loss of vision in one eye †Tunnel vision
†Flashing lights Loss of vision on one side † Double vision
†Zigzag lines †Total blindness †Other _____

Do the symptoms spread? †Yes- spreads slowly † No- begins all at once
The visual symptoms start: †Before the headache pain †During the headache pain

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

The visual symptoms last for: _____ minutes _____ hours

How long does the aura last before head pain starts? _____ minutes _____ hours

How long does the aura and head pain last together? _____ minutes _____ hours

If you have more than one symptom, do they happen: †All at once† Separately
Do you ever have visual aura without headache pain? †Yes † No

Sensory

†Numbness/ tingling- right †Numbness/ tingling- left †Numbness/ tingling- both
†Dizziness/ unsteadiness †Vertigo †Light headedness
†One- sided weakness † General weakness †Speech difficulty
†Unable to speak †Other (describe) _____

Do the symptoms spread? †Yes- spreads slowly † No- begins all at once
The sensory symptoms start: †Before the headache pain †During the headache pain

The sensory symptoms last for: _____ minutes _____ hours

How long does the aura last before head pain starts? _____ minutes _____ hours

How long does the aura and head pain last together? _____ minutes _____ hours

If you have more than one symptom, do they happen: †All at once† Separately
Do you ever have sensory aura without headache pain? †Yes † No

Do you have any other auras? †Yes †No (describe) _____

Premonitory Symptoms:

Do you experience any of these symptoms before the onset of your headaches? (Check all that apply)

†Heightened feeling of wellness †Difficulty concentrating†Increased appetite
†Hyperactive † Sensitive to light †Decreased appetite
†Extremely talkative † Sensitive to noise/ sound †Feeling cold
†Depressed feeling †Sensitive to odors †Diarrhea
†Irritability †Difficulty with speech † Constipation
†Feeling sluggish †Excessive yawning †Extremely thirsty
†Drowsy †Neck stiffness †Increased urination
†Restless †Food cravings †Fluid retention
†Dizziness †Weakness †Other

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

Provoking Factors: Things that bring on my headache (Check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| Food/ Beverage: | †Fasting | †Chocolate | †Caffeine | †Nitrates | |
| | †MSG | † Alcohol | †Wine | † Other _____ | |
| Physical Exertion: | †Coughing | †Talking | †Chewing | †Exercise | |
| | †Sexual Intercourse | † Other | | | |
| Hormonal: | Menses: | †Before | †During | †After | |
| | Pregnancy | †Menopause | | | |
| Stress: | †Work | † Home | †Family | †Other _____ | |
| | †Let down after stressful situation | | | | |
| Environmental: | † Allergies | †Weather | †Altitude | †Sunlight | |
| Sleep: | †Less sleep | †Too much sleep | † Change in wake/ sleep | | |

Other triggers: (describe)_____

Relieving Factors: Things that improve my headache (Check all that apply)

| | | |
|---|---|---|
| †Lying down | † Dark quiet room | †Massage |
| †Hot compress | †Cold compress | †Pregnancy |
| †Keeping active/ pacing | †Standing | †Other _____ |

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

**Headache Type #2:** (If no 2nd headache type skip ahead 4 pages to 'Quality of Life Review')

Date of onset of first headache: _____

Precipitating Event (what provoked your first headache):

†None known †Injury (describe) _____

†Menarche (1st Menstrual Period) †Pregnancy

†Other (describe) _____

Pattern of Onset: †Sudden † Rapid † Gradual †Varies

Timing of headache: †Morning † Afternoon † Evening †Night

†Awakens from sleep Varies

Periods of increased frequency: †Weekends †Weekdays †Vacation

†Seasonal (Spring/ Summer/ Fall/ Winter)

Frequency of attacks: # per day † # per week† # per month†

# per year† # of lifetime attacks† continuous†

Are they increasing in frequency? †Yes †No

Duration: (How long do they last?)

With medication lasts: _____minutes _____hours†_____days

How often does it recur within 24 hours? ___% of time

Without medication lasts: _____minutes _____hours†_____days

How often does it recur within 24 hours? ___% of time

Severity (How bad is the pain on a scale from 0 to 10 <where 0 is no pain and 10 is the worst>)

Lowest and highest level of pain for this headache type:

Low _____ High _____

Usual severity of this headache type: _____

Worse with menses? †Yes †No

Allodynia:

Do you experience pain or unpleasant sensation *on your skin* during an attack when you:

| | | | | | |
|---|---|---|---|---|---|
| Comb your hair† | Yes | †No | Pull your hair back | †Yes | †No |
| Shave | †Yes | †No | Wear glasses | †Yes | †No |
| Wear contacts | †Yes | †No | Wear earrings | †Yes | †No |
| Wear necklaces† | Yes | †No | Take a shower | †Yes | †No |
| Expose to heat/ cold | †Yes | †No | Rest head on pillow | †Yes | †No |

Location: †Temples †Back of Head Side of Head †Front of Head

†Around head † Eye † Ear † Neck

†Jaw † Other (describe)_____

Sidedness: †Left-sided †Right-sided

†Both sides †Varies

Change sides: †Between attacks †During attacks †Both between and during

Character: †Throbbing/ Pulsing † Pressure †Achy

†Burning †Tight † Searing

†Dull † Shooting †Stabbing

†Other (describe) _____

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

Activities that worsens headache: †None †Walking
†Climbing steps †Exercise
†Other (describe) _____

Headache disability during or immediately after an attack:
†Normal activity †Slight decrease in function
†Moderate decrease in function †Severe decrease in function
†Confined to bed

| Associated features: | Nausea † | Vomiting |
|---|---|---|
| †Light Sensitive | Sound Sensitive | Smell Sensitive |
| †Diarrhea | Constipation | Insomnia |
| †Increased Urination | Increased appetite | Decreased appetite |
| †Sore/ stiff neck | Ringing in ears | Blurred vision |
| †Eye Tearing (R/L/B) | Anxiety | Poor Concentration |
| †Nose Congested (R/L/B) | Irritability | Memory Problems |
| †Drooping Eyelid (R/L/B)† | Confusion | Change in Pupil |
| †Language Problems | Visual spotting | Skin sensitivity |
| †Other (describe) _____ | | |

Aura: Do you have any of these symptoms before your headache begins? (Check all that apply)

Visual

| | | |
|---|---|---|
| †Blurry vision | Loss of vision in one eye | Tunnel vision |
| †Flashing lights | Loss of vision on one side | Double vision |
| †Zigzag lines | Total blindness | Other _____ |
| Do the symptoms spread? | Yes- spreads slowly | No- begins all at once |
| The visual symptoms start: | Before the headache pain | During the headache pain |

The visual symptoms last for: _____ minutes _____ hours

How long does the aura last before head pain starts? _____ minutes _____ hours

How long does the aura and head pain last together? _____ minutes _____ hours

If you have more than one symptom, do they happen: †All at once †separately
Do you ever have visual aura without headache pain? †Yes †No

Sensory

| | | |
|---|---|---|
| †Numbness/ tingling- right | Numbness/ tingling- left | Numbness/ tingling- both |
| †Dizziness/ unsteadiness | Vertigo | Light headedness |
| †One- sided weakness | General weakness | Speech difficulty |
| †Unable to speak | Other (describe) _____ | |

| | | |
|---|---|---|
| Do the symptoms spread? | †Yes- spreads slowly | No- begins all at once |
| The sensory symptoms start: | †Before the headache pain | During the headache pain |

The sensory symptoms last for: _____ minutes _____ hours

Name: _____ DOB: _____/_____/_____

How long does the aura last before head pain starts? _____ minutes _____ hours

How long does the aura and head pain last together? _____ minutes _____ hours

If you have more than one symptom, do they happen: † All at once †separately
Do you ever have sensory aura without headache pain? † Yes †No

Do you have any other auras? †Yes †No (describe) _____

Premonitory Symptoms:
Do you experience any of these symptoms before the onset of your headaches? (Check all that apply)

†Heightened feeling of wellness †Difficulty concentrating †Increased appetite

| | | |
|---|---|---|
| †Hyperactive | †Sensitive to light | Decreased appetite |
| †Extremely talkative | †Sensitive to noise/ sound | †Feeling cold |
| †Depressed feeling | †Sensitive to odors | Diarrhea |
| †Irritability | †Difficulty with speech | Constipation |
| †Feeling sluggish | †Excessive yawning † | Extremely thirsty |
| †Drowsy | †Neck stiffness † | Increased urination |
| †Restless | †Food cravings | Fluid retention |
| †Dizziness | †Weakness | †Other |

Provoking Factors: Things that bring on my headache (Check all that apply)

Food/ Beverage: †Fasting †Chocolate †Caffeine †Nitrates
†MSG †Alcohol †Wine †Other _____
Physical Exertion: †Coughing †Talking †Chewing †Exercise
†Sexual Intercourse †Other _____
Hormonal: †Menses: (if so, then) †Before †During †After
†Pregnancy †Menopause
Stress: †Work †Home †Family †Other _____
† Let down after stressful situation
Environmental: †Allergies †Weather †Altitude †Sunlight
Sleep: †Less sleep †Too much sleep †Change in wake/ sleep

Other triggers: (describe)_____

Relieving Factors: Things that improve my headache (Check all that apply)

| | | |
|---|---|---|
| †Lying down | † Dark quiet room | †Massage |
| †Hot compress | †Cold compress | †Pregnancy |
| †Keeping active/ pacing | †Standing | †Other _____ |

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

**Quality of Life Review:**

1. My appetite over last 1 month has: †Increased †Decreased †No change
   My energy over last 1 month has: †Increased †Decreased †No change
   My mood over the last 1 month is: †Better †Worse †No change

   My mood can be described as: (check all that apply)
   †Anxious †Calm †Depressed
   †Euphoric †Irritable †Angry
   †Rageful †Tearful †Other _____

2. I get _____ hours of continuous sleep per night.

   Check all that apply:
   †I have no trouble falling asleep
   †I have trouble staying asleep
   †I snore
   †I have sleep apnea
   †My headache awakens me
   †I wake up during the night or early morning for no apparent reason
   I have difficulty falling asleep
   I sleep too much
   I sleepwalk
   I talk in my sleep
   I wake up with a headache

3. My sexual function is: (check all that apply)
   †Normal †No change No orgasm
   †Increased libido †Decreased libido †Erectile problems
   †Other (describe) _____

4. Headache's effect on ability to function:
   Work productivity: †days/ month missed
   School productivity: †days/ month missed
   Social/ family activities: † days/ month missed

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

**Previous Treatments and Testing:**

**Previous Treatments** (Please give name of provider, date, type of treatment and if it helped)

- Primary care provider _____
- Neurologist _____
- Otolaryngologist (ENT) _____
- Dentist/ dental _____
- Chiropractor _____
- Ophthalmologist _____
- Psychiatrist/ psychologist _____
- Biofeedback/ relaxation _____
- Physical therapy _____
- Massage _____
- Acupuncture/ acupressure _____
- Herbal/ homeopathic medicine _____
- Other (describe) _____

**Previous Testing** (Please give date and results)

| | | | |
|---|---|---|---|
| Head MRI | _____ | EEG | _____ |
| MRA/ MRV | _____ | Lumbar Puncture | _____ |
| Cervical MRI | _____ | EKG | _____ |
| Lumbar Spine MRI | _____ | EMG | _____ |
| Head CT | _____ | Sleep Study | _____ |

Other (describe) _____

**Interventions** (Please give date and results)

| | | | |
|---|---|---|---|
| Trigger Point Injection | _____ | Occipital Nerve Block | _____ |
| Botulinum (Botox) | _____ | Other Nerve Block | _____ |
| Acupuncture | _____ | Other | _____ |

Northwell Health
Physician Partners

**Preventive Medications**

Please circle any medications that you have taken for your headaches

Abilify (aripiprazole)
Atacand (candasartan)
Ativan (lorazepam)
Botox
Buspar
Butterbur
Calan
Cardizem (diltiazem)
Cataflam (diclofenac)
Catapres (clonidine)
Celebrex
Celexa (citalopram)
Clinoril (sulindac)
Coenzyme Q-10
Corgard
Cymbalta
Depakote (Valproate)
Dilantin (phenytoin)
Effexor XR
Elavil (amitryptiline)
Feverfew
Flexeril
Gabitril
Geodon (ziprasidone)
Haldol
Imipramine
Procardia (nifedipine)
Keppra
Klonopin (clonazepam)
Lamictal
Lexapro (escitalopram)
Librium
Limbitrol
Lithium
Luvox
Lyrica (Pregabalin)
Magnesium
Melatonin
Methergine
Migralief/ Migrahealth
Nardil
Navane (thiothixene)
Nerve blocks
Neurontin (gabapentin)
Norpramin (desipramine)
Norvasc (amlodipine)
Pamelor (nortriptyline)
Parafon Forte
Parnate
Periactin
Petadolex
Paxil (paroxetine)
Plendil (felodipine)
Prestiq
Indocin (indomethacin)
Remeron (mirtazapine)
Sansert
Savella
Seroquel (quetiapine)
Serzone
Sinequan (doxepin)
Tegretol (carbamazepine)
Tenormin (atenolol)
Tofranil
Topamax
Toprol XA (metoprolol)
Trigger Point Injections
Trileptal
Triavil
Ultram (tramadol)
Valium (diazepam)
Verapamil
Vitamin B2 (Riboflavin)
Vivactil
Wellbutrin
Xanax (alprazolam)
Zanaflex (tizanidine)
Zoloft (sertraline)
Zonegran (zonisamide)
Zyban
Zyprexa (olanzapine)
Inderal (propranolol)
Prozac (fluoxetine)
Risperdal

**Abortive Medications:** Please circle any medications that you have taken for your headaches

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

Advil (ibuprofen)
Aleve (naproxen)
Amerge (naratriptan)
Anaprox (naproxen sodium)
Antivert (meclizine)
Arthrotec
Aspirin
Avinza
Axert
Bellergal
Benadryl (diphenhydramine)
Cafergot
Celebrex
Celexa
Clinoril (sulindac)
Codeine
Compazine (prochlorperazine)
Darvocet
Darvon
Daypro
Decadron (dexamethasone)
Demerol (meperidine)
DHE
Dilaudid (hydromorphone)
Dolobid (diflunisal)
Duragesic patch
Excedrin
Feldene
Feverfew
Fioricet
Fioricet with codeine
Fiorinal
Fiorinal with codeine
Flexeril
Frova
Haldol
Hydrocodone
Imitrex tabs (sumatriptan)
Imitrex nasal spray
Imitrex injections
Indocin (indomethacin)
Klonopin (clonazepam)
Lortab
Maxalt (rizatriptran)
Medrol Dose Pak
Methadone
Methergine
Midrin
Migralief/ Migrahealth
Migranal
Morphine
Motrin (ibuprofen)
MS Contin
MSIR
Naprosyn
Navane (thiothixene)
Nembutal
Norflex
Norgesic
Orudis (ketoprofen)
Oxy IR/ Oxycodone
OxyContin
Parafon Forte
Percocet
Percodan
Phenergan (Promethazine)
Phrenelin
Prednisone (prednisolone)
Reglan (metoclopramide)
Relafen (nabumetone)
Relpax (eletriptan)
Robaxin (methocarbamol)
Skelaxin (metaxalone)
Soma
Stadol
Talwin
Thorazine (chlorpromazine)
Toradol (ketorolac)
Tylenol (acetaminophen)
Valium (diazepam)
Vicodin
Vioxx
Voltaren (diclofenac)
Xanax (alprazolam)
Zanaflex (tizanidine)
Zomig (zolmitriptan)
Zyprexa (olanzapine)

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

# Medication List

**Current Medications**

Please list ALL current medications and daily dosages. Include over-the-counter medications, vitamins, and homeopathic treatments in addition to prescribed medications

| Medication | Daily Dosage | Side Effects Results |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Medication | Daily Dosage | Side Effects Results |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Previous Headache Medications**

Please list ALL previous medications used for headache management.

| Medication | Daily Dosage | Side Effects Results |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Medication | Daily Dosage | Side Effects Results |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

**Allergies:**

†Foods †Medicines †Dye/ iodine †Seafood †Other (please name)
_____

What type of reaction did you have? (describe) _____

**Past Medical History:**

General Health: †Excellent †Good †Fair †Poor

Have you had any of the following medical problems?

†Diabetes †Arthritis †Asthma
†Hypertension †Cervical Neck/ spine problems †Heart disease †Skin problems
†Ulcers/Gastrointestinal problem †Cancer
†Kidney/renal disease †Stroke/transient ischemic attack †Head injury
†Infectious disease †Seizures/ epilepsy †Psychiatric
†Hepatitis/liver disease †Gynecologic problems †Thyroid disease
†Dental problems †Deep vein thrombosis/phlebitis †Pulmonary disease
†Ear/Nose/Throat problems †Elevated Cholesterol †Heart Attack
†Other (describe) _____

Have you ever been hospitalized or had surgery? (List reason, date, hospital)
_____
_____

Menstrual History:

Menarche (age of onset) _____ ___ Are you still menstruating? †y †n
Last menstrual period _____ Menses occurs monthly? †y †n

Cycle length _____ If not monthly, every _____

Character _____ Reason for menopause _____

Obstetrical History

Total Pregnancies _____ †Living _____
†Full term babies _____ †Induced abortions _____
†Premature _____ † Miscarriages _____

Are you currently sexually active?

† Yes † No

Current method of contraception: _____

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

**Social History:**

Living in: †Home †Apartment †Other _____
Living in household †# of people_____ †# of children_____ †# children < 18_____
Education †Some high school †High school/ GED †Some college
†College degree †Post grad school † Grade _____
Employment Status †Part-time †Full-time †Retired
†Disabled (please describe why) _____
†Type of work: _____

**Risk Factors:**

I drink or drank: Alcohol: # _____ †day †week †month
Year began _____ Year stopped _____
Drug use: †Marijuana †Cocaine †Heroin †Other _____
Year began _____ Year stopped _____
Tobacco history: I have never smoked †I used to smoke †I smoke now
I smoked # _____ †day †week †month
Year you quit smoking:†
Caffeine use: I drink # ____ caffeinated beverages †day †week
Seatbelt use: I wear a seatbelt regularly †yes †no

**Lifestyle Factors:**

Do you exercise? †yes †no How often?_____
Are you on any special diet? †yes †no What type?_____
Any recent weight loss/gain?† yes †no How much?_____

**Family History:**

Do you know of any blood relative who has had:
†Heart disease † Hypertension †Stroke †Arthritis †Headache
†Neurologic disease †Asthma †Cancer †Diabetes †Liver disease
†Thyroid disease Alcoholism †Addiction †Anxiety †Depression
†Irritable Bowel Fibromyalgia †None (non-contributory)

Please explain: _____

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

**Review of Systems:**

Have you been having any of the following symptoms **NOT** associated with your headache over the last 6 months?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fever | yes | no | | Shortness of breath | yes | no | |
| Tremors | yes | no | | Fatigue | yes | no | |
| Nausea | yes | no | | One-sided weakness | yes | n | |
| Double vision | yes | no | | Constipation | yes | no | |
| Vertigo | yes | no | | Diarrhea | yes | no | |
| Loss of consciousness | yes | no | | Rash | yes | no | |
| Abdominal pain | yes | no | | Obstructed vision | yes | no | |
| Frequent urination | yes | no | | Tearing | yes | no | |
| Irregular periods | yes | no | | Anxiety | yes | no | |
| Back Pain | yes | no | | Depression | yes | no | |
| Blurry vision | yes | no | | Neck pain | yes | no | |
| Recent weight loss | yes | no | | Congestion | yes | no | |
| Muscle soreness | yes | no | | Recent weight gain | yes | no | |
| Ringing in the ear | yes | no | | Flashing lights | yes | no | |
| Heat intolerance | yes | no | | Cold intolerance | yes | no | |
| Chest pain | yes | no | | Cold hands and feet | yes | no | |
| Bruise easily | yes | no | | Rapid heartbeats | yes | no | |
| Leg/ Foot swelling | yes | no | | Lightheadedness | yes | no | |
| Shakiness | yes | no | | Hay fever symptoms | yes | no | |
| None of the above | yes | no | | All others are negative | yes | no | |

**Additional Comments:**

_____

_____

_____

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

## Alternative and Complementary Medicine Questionnaire

**Please answer all questions to the best of your ability. If you have not participated in the activity than answer 'No' and move on to the next question.**

| Description of activity | Have you participated in this treatment? | | For what condition did you use this treatment? | For how many weeks did you participate? | For how many sessions did you participate? | Did you find benefit with this treatment? | |
|---|---|---|---|---|---|---|---|
| | Yes | No | (write in answer) | (insert #) | (insert #) | Yes | No |
| 1. Acupressure | | | | | | | |
| 2. Acupuncture | | | | | | | |
| 3. Alexander Technique | | | | | | | |
| 4. Aromatherapy | | | | | | | |
| 5. Art Therapy | | | | | | | |
| 6. Aura Therapy | | | | | | | |
| 7. Autogenics | | | | | | | |
| 8. Autosuggestion | | | | | | | |
| 9. Bach Flower Remedies | | | | | | | |
| 10. Biochemic Salts | | | | | | | |
| 11. Biofeedback | | | | | | | |
| 12. Chiropractic | | | | | | | |
| 13. Coining | | | | | | | |
| 14. Cranial Osteopathy | | | | | | | |
| 15. Cranial Sacral Therapy | | | | | | | |
| 16. Crystal Healing | | | | | | | |
| 17. Cupping | | | | | | | |
| 18. Dance Therapy | | | | | | | |
| 19. Diet | | | | | | | |
| 20. Feldenkrais Method | | | | | | | |
| 21. Herbal Medicine | | | | | | | |
| 22. Homeopathy | | | | | | | |
| 23. Hydrotherapy | | | | | | | |
| 24. Hypnotherapy | | | | | | | |
| 25. Iridology | | | | | | | |
| 26. Kinesiology | | | | | | | |
| 27. Macrobiotics | | | | | | | |
| 28. Massage Therapy | | | | | | | |
| 29. Meditation | | | | | | | |
| 30. Maxibustion | | | | | | | |

## Alternative and Complementary Medicine Questionnaire

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

**Please answer all questions to the best of your ability. If you have not participated in the activity than answer 'No' and move on to the next question.**

| Description of activity | Have you participated in this treatment? | | For what condition did you use this treatment? | For how many weeks did you participate? | For how many sessions did you participate? | Did you find benefit with this treatment? | |
|---|---|---|---|---|---|---|---|
| | Yes | No | (write in answer) | (insert #) | (insert #) | Yes | No |
| 31. Naturopathy | | | | | | | |
| 32. Negative Ion Therapy | | | | | | | |
| 33. Osteopathy | | | | | | | |
| 34. Physical Therapy | | | | | | | |
| 35. Reflexology | | | | | | | |
| 36. Rolfing | | | | | | | |
| 37. Pilates | | | | | | | |
| 38. Prolotherapy | | | | | | | |
| 39. Qi Gong | | | | | | | |
| 40. Shiatsu | | | | | | | |
| 41. T'ai Chi Ch'uan | | | | | | | |
| 42. Thalassotherapy | | | | | | | |
| 43. Trepanation | | | | | | | |
| 44. Yoga | | | | | | | |
| 45. Other _____ | | | | | | | |

Name: _____ DOB: _____/_____/_____

Northwell Health
Physician Partners

**Migraine Disability Assessment***

**Patient's Name:**_____
**Date of Birth:** _____/_____/_____
**Date:** _____/_____/_____

**Instructions:** Please answer the following questions about ALL the headaches you have had over the last three (3) months. Write your answer in the box next to each question. Write zero (0) 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? | **DAYS** |
| **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.)* | **DAYS** |
| **3.** On how many days in the last 3 months did you not do household work because of your headaches? | **DAYS** |
| **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 #3 where you did not do household work)* | **DAYS** |
| **5.** On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches? | **DAYS** |
| **6.** On how many days in the last 3 months did you have a headache? *(If a headache lasted more than one (1) day, count each day)* | **DAYS** |
| **7.** On a scale of 0 to 10, on average how painful were these headaches? *(Where 0 = no pain at all and 10 = pain as bad as it can be)* | **PAIN** |

Northwell Health
Physician Partners

Department of Neuroscience

Date:_____

Patient Name:_____ DOB:_____

**Advance Directives** (Applicable to patients over the age of 18 years)

| | | |
|---|---|---|
| **Do you have a health care proxy (Advance Directive)**<br>(If yes, please ask patient for a copy and place in the chart today or at the next visit) | **Yes** | **No** |
| **Do you want more information on a Health Care Proxy?**<br>(If yes, please give patient an Advanced Directives brochure) | **Yes** | **No** |
| **Do you desire help in creating a Health Care Proxy?**<br>(If yes, refer to the Department of Social Work at (718) 470-7540) | **Yes** | **No** |

**Smoking Cessation**

| | | |
|---|---|---|
| **Have you ever smoked?** | **Yes** | **No** |
| **If yes, have you smoked in the past 12 months?**<br>(If yes, please give patient smoking cessation brochure.) | **Yes** | **No** |

**Passport to Health**

| | | |
|---|---|---|
| **Would you like a Passport to Health, a tool which will help you keep track of your medical history, prescriptions and advance directives?** | **Yes** | **No** |

---

**Initial Patient Visit Health Information Reviewed and Addressed by Neuroscience Staff Member:**

_____ _____

**(Neuroscience Staff Member Signature)** **(Date)**