NEW YORK HEADACHE CENTER

www.NYHeadache.com

Patient Information

Date …… Marital status……

Name ……

Street address……

……

Home phone ……..Business phone……

e-mail……Date of birth ……..

Social security #..... Occupation……..……

Employer……

Street address ..……

……

Insurance……

Referring physician ..……

Street address/phone ……..……

……

Any other doctors you would like us to send a report to:……..

Referred by (friend, media, etc.)……..……

Problem……

……

……

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

Brooklyn:
132 Atlantic Avenue,
Brooklyn, NY 11201
Tel: 718-935-9666

Westchester:
2 Greenridge Avenue,
White Plains, NY 10605
Tel: 212-794-3550

Medical History 1

Patient Name……..…….Date……

Please list all doctors you have seen in the past two years for any reason:

……

……

……

Since the LAST VISIT, are you: ☐ BETTER ☐ WORSE ☐ THE SAME

Do you have any NEW problems/new medications? ☐ Yes ☐ No.

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

Y	N		Y	N	
☐	☐	Change in marital status.....	☐	☐	Cold extremities.....
☐	☐	Change in job/school.....	☐	☐	Leg/foot cramps.....
☐	☐	Emotional trauma.....			
☐	☐	Change in smoking/drinking/diet	☐	☐	Depression.....
			☐	☐	Anxiety/panic attacks.....
☐	☐	Hospitalization/surgery.....			
☐	☐	Fatigue.....	☐	☐	Change in skin/hair.....
☐	☐	Weight loss/gain:.....	☐	☐	Excessive urination or thirst.....
☐	☐	Allergic reaction.....			
☐	☐	New illness diagnosed.....	☐	☐	Insomnia.....
☐	☐	Fever/chills.....	☐	☐	Leg restlessness.....
			☐	☐	Daytime sleepiness.....
☐	☐	High blood pressure.....	☐	☐	Snoring.....
☐	☐	Palpitations.....	☐	☐	Sleep apnea.....
☐	☐	Breathing difficulty.....	☐	☐	Teeth grinding/clenching.....
☐	☐	Chest pain.....			
☐	☐	Swelling.....	☐	☐	Seizures/shaking.....
			☐	☐	Headaches.....
☐	☐	Chronic cough.....	☐	☐	Back pain.....
☐	☐	Wheezing.....	☐	☐	Neck pain.....
			☐	☐	Decline in memory.....
☐	☐	Bleeding/bruising.....	☐	☐	Weakness.....
			☐	☐	Numbness.....
☐	☐	Diarrhea.....	☐	☐	Hearing/vision problems.....
☐	☐	Constipation.....	☐	☐	Loss of consciousness.....
☐	☐	Nausea/vomiting.....	☐	☐	Dizziness.....
☐	☐	Joint pain/swelling/redness.....	☐	☐	Dental problems.....
☐	☐	Muscle aches.....	☐	☐	Sinus problems.....
			☐	☐	Hoarseness.....
☐	☐	Sexual dysfunction.....	☐	☐	Any other problems not listed.....
☐	☐	Breast lumps/discharge.....			.....
☐	☐	Symptoms of menopause.....			
☐	☐	Irregular periods.....			
☐	☐	PMS.....			
☐	☐	Bladder problems.....			

Patient Signature.....

Reviewed with patient on: .....

MD signature: .....

Medical History 2

Patient Name……..…….....Date……

Please check the past treatments you have had:

☐ Tens	☐ Surgery	☐ Acupuncture
☐ Botox	☐ Psychotherapy	☐ Biofeedback
☐ Homeopathy	☐ Special diets	☐ Chiropractic
☐ Other:……		☐ Hot or cold

Prior evaluations (please check):

☐ Neurological exam	☐ Angiogram	☐ X-ray of ……
☐ CAT scan	☐ Eye exam	☐ Psychiatric/psychological
☐ EEG	☐ Dental exam	☐ EMG (Nerve & Muscle)
☐ MRI scan	☐ ENT exam	☐ Spinal tap

Other……..

Please list all your present medical problems:

……
……
……

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

……
……
……

Please list your allergies, if any:……
……

Is there a family history of (please check):

☐ Headaches	☐ Arthritis	☐ Mental illness	☐ Seizures
☐ Alcoholism	☐ Obesity	☐ Strokes	☐ Goiter
☐ Excessive bleeding	☐ Heart disease	☐ Diabetes	☐ Cancer
☐ High blood pressure	☐ Tuberculosis	☐ Other……	

Amounts per day: Alcohol…….....Beer……..Coffee …….Tea …….Tonic/soda ……
If you smoke, how much? ……..

Physical exercise/frequency/duration:

……
……

Present work status:……
If you have children, please list their ages:……..
Please list hobbies/recreational activities:……
Other:……

Medical History 3

Patient Name……..…….Date……

Do you now have, or have you ever had, any of the following:

- ❑ Head or neck injury, even if minor, including "whiplash". Describe (include dates):
- ❑ Loss of consciousness
- ❑ Brain infection
- ❑ Seizures
- ❑ High blood pressure
- ❑ Palpitations
- ❑ Chest pain
- ❑ Other heart disease
- ❑ Kidney disease
- ❑ Urinary tract infection
- ❑ Asthma
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Sinus problems
- ❑ Birth abnormality
- ❑ Skin spots
- ❑ Ulcers
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Diabetes Mellitus
- ❑ Abnormal blood sugar.
- ❑ Thyroid disease
- ❑ Recent weight change
- ❑ Frequent infections
- ❑ Cold sores (fever blisters) on the lips or the mouth.
- ❑ Arthritis/joint pain.
- ❑ Skin rash
- ❑ Anemia
- ❑ Blood/bleeding/clotting problems
- ❑ Bruising
- ❑ Depression
- ❑ Anxiety
- ❑ Panic attacks
- ❑ Other psychiatric problem
- ❑ Cancer or tumor of any part of the body
- ❑ Motion sickness
- ❑ Vertigo/dizziness
- ❑ Lyme Disease
- ❑ Chronic Fatigue
- ❑ Fibromyalgia
- ❑ Epstein Barr
- ❑ Teeth grinding or clenching
- ❑ Allergies. Describe:
- ❑ Any other condition for which you are under medical care? Explain:
- ❑ Any surgery. Explain, with dates:
- ❑ Unusual childhood illnesses. Explain:

Please list all prescription pills you now take for any medical condition (including birth control pills) other then headaches:……
……
……

Please list any pills you take that do not require a prescription (vitamins, Tylenol, cold medicines, herbal supplements, etc.): ……
……
……

Sleep History:

How many hours do you sleep each night: ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ variable
What time do you physically get into bed at night:…….. Every night?: ❑ Yes ❑ No.
What time do you get up in the morning:…….. Every morning?: ❑ Yes ❑ No.
How many minutes does it take you to fall asleep:…….
How deep is your sleep: ❑ light ❑ medium ❑ heavy
Do you awaken refreshed: ❑ Yes ❑ No.
Are you sleepy during the day or evening (do you fall asleep if inactive, ex. watching TV): ❑ Yes ❑ No.
Have you ever had any unusual sleep-related problems, in childhood or as an adult: ❑ Yes ❑ No.
Do you snore: ❑ Yes ❑ No.
Do you awaken during the night: ❑ Yes ❑ No.
Do you have irritating feeling in your legs when relaxing, trying to fall asleep, or on long trips: ❑ Yes ❑ No.
Does anyone in your family have sleeping problems of any sort: ❑ Yes ❑ No.
If yes, describe: ……..

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Headache History 1

Patient Name……..…….Date…….……

Have you ever been treated for headaches: ☐ Yes ☐ No.

What kind of headaches were you told you have:.....

Have you had any tests done to diagnose your headaches: ☐ Yes ☐ No.
Describe:.....

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

Anaprox	Codeine	Fioricet/butalbital	Neurontin/gabapentin	Talwin
Aspirin/Anacin	Darvon/ Darvocet	Fiorinal	Naprosyn	Topamax
Axert/Advil/Buprofen	Dexamethasone	Flexeril	Panadol	Tylenol
Aleve/Naproxen	Decongestants	Frova	Pamelor/nortriptyline	Valium
Amerge	DHE-45	Imitrex	Percocet/oxycodone	Verapamil
Axotal	Demerol	Inderal	Percodan	Vivactyl
Amitriptyline/Elavil	Depakote	Lamictal	Percogesic	Wigraine
Antihistamines	Desyrel	Lidocaine	PhrenilinForte	Xanax
Atacand	Dilantin/phenytoin	Lithium	Propanolol	Zanaflex
Bellergal	Esgic	Maxalt	Relpax	Zomig
Bufferin	Empirin	Midrin/Duradrin	Robaxin	Zonegran
Cafergot	Ergostat	Migranal	Sansert	Other:
Calan	Excedrin	Motrin/ibuprofen	Stadol	

*** Star those which helped, even for a while.**

Have you tried any of he following alternative treatments (circle):

Biofeedback Acupuncture Chiropractic Supplements (feverfew, B2, magnesium, MigreLief, CoQ10, butterbur, Petadolex) Physical Therapy, Other:

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

Drug Name	Strength (Mg)	# Each Day or Week
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-
-	-	-

Headaches History 2:

Patient Name……..…….....Date……

At what age did you have the very first headache you can remember:……

Describe any details of that headache that you can recall:……

What year did your **current** headaches begin:……..

Did anything trigger them:……

Have they changed or become worse:……When:……

When was your last headache:……

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 (circle one or several):

Throbbing/pulsating dull/aching pressure-like sharp stabbing electric-like vise-like other:……..

Does the pain feels like (1) ☐ going from outside – in (compressing, stabbing in) or (2) ☐ from the inside – out (exploding, pushing out).

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 or worsened 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,

Are your headaches worse at any particular day of the week:……

At what time of day does the pain usually begin:……..

Do you have any warning signs **before** the start of a headache: ☐ Yes ☐ No. Describe:……..

……...

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

Neck pain Nausea Vomiting Light sensitivity Dizziness Noise sensitivity Numbness Weakness Fever Confusion Difficulty speaking Tearing Nasal congestion Eyelid drooping Other:……

……

Midas Questionnaire
Migraine Disability Assessment

Patient name:……
Date:……
This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor findthe best treatment for you.

INSTRUCTIONS: Please answer the following questions about all of your headaches over the last **3 months.** Write youranswer 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? ☐ .

(Questions 1-5) TOTAL

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 headaches? (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).

Midas Grade	Definition	Midas Score
I	Little or no disability	0-5
II	Mild disability	6-10
III	Moderate disability	11-20
IV	Severe disability	21+

* **Females only**:

Patient Name……..…….Date……..…..

Age menstrual periods began:.....Were your periods regular through your life: ☐ Yes ☐ No.

Number of days between each period (from day 1 to day 1):.....Bleeding is: ☐ Heavy ☐ Medium ☐ Light

Have you ever taken birth control pills: ☐ Yes ☐ No

Are you now taking birth control pills: ☐ Yes ☐ No. if yes, which one.....

With birth control pills did you feel: ☐ better ☐ worse ☐ the same

Which symptoms (if any) do (did) you have before your period: ☐ headache ☐ irritability ☐ depression ☐ sleepiness ☐ cramps ☐ insomnia ☐ bloating ☐ breast tenderness

Have you ever been pregnant: ☐ Yes ☐ No. If yes, how many times:.....

If yes, were your headaches: ☐ better ☐ worse ☐ the same during pregnancy.

Have you gone through menopause: ☐ Yes ☐ No

Have you had any changes which you feel are pre menopausal: ☐ Yes ☐ No

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

Social History:

Level of education:.....

Marital Status:.....Number of years of marriage, if still married:.....

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

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

.....

Current occupation: .....

How many hours/ week do you work:..... Do you like your job?: ☐ Yes ☐ No ☐ Not sure

Habits:

How many cigars/ cigarettes do you smoke each day: ☐ 0 ☐ 1-5 ☐ 5-10 ☐ 10-20 ☐ 20+

How many alcoholic drinks do you consume each **week**: ☐ 0 ☐ 1-3 ☐ 4-5 ☐ 5+

How many caffeinated drinks do you consume each day: ☐ 0 ☐ 1-3 ☐ 4-5 ☐ 5+

Do you use any "recreational drugs": ☐ none ☐ marijuana ☐ cocaine ☐ other

How many hours do you exercise each week:..... Doing what:.....

Do you eat meals at regular intervals: ☐ Yes ☐ No.

Do you have any special dietary habits:.....

Do you eat much "junk food": ☐ Yes ☐ No. If "yes', what kind: .....

Hobbies:.....

Patient Name……..…….....Date……

Emotions play a role in most illness, including headaches. If I know about these feelings I can help you more. This last questionnaire is designed to help me know how you feel. Read each item and underline, check or circle the reply which comes closest to how you have been feeling in the past few weeks. Your first response will be the most accurate.

I feel tense or wound up:

- ☐ Most of the time
- ☐ A lot of the time
- ☐ Only occasionally
- ☐ Not at all

I still enjoy the things I used to enjoy:

- ☐ Definitely as much
- ☐ Not quite so much
- ☐ Only a little
- ☐ Hardly at all

I get a sort of frightened feeling as if something awful is about to happen:

- ☐ Very definitely and quite badly
- ☐ Yes, but not too badly
- ☐ A little, but it doesn't worry me
- ☐ Not at all

I can laugh and see the funny side of things:

- ☐ As much as I always could
- ☐ Not quite so much now
- ☐ Definitely not so much now
- ☐ Not at all

I feel restless as if I have to be on the move:

- ☐ Very much indeed
- ☐ Quite a lot
- ☐ Not very much
- ☐ Not at all

I look forward with enjoyment to things:

- ☐ As much as I ever did
- ☐ Rather less than I used to
- ☐ Definitely less than I used to
- ☐ Hardly at all

Worrying thoughts go through my mind:

- ☐ A great deal of the time
- ☐ A lot of the time
- ☐ From time to time but not too often
- ☐ Only occasionally

I feel cheerful:

- ☐ Not at all
- ☐ Not often
- ☐ Sometimes
- ☐ Most of the time

I can sit at ease and feel relaxed:

- ☐ Definitely
- ☐ Usually
- ☐ Not often
- ☐ Not at all

I feel as if I am slowed down:

- ☐ Nearly all the time
- ☐ Very often
- ☐ Sometimes
- ☐ Not at all

I get a sort of frightened feeling like "butterflies'

- ☐ Not at all
- ☐ Occasionally
- ☐ Quite often
- ☐ Very often

I have lost interest in my appearance:

- ☐ Definitely
- ☐ I don't take as much care as I should
- ☐ I may not take quite as much care
- ☐ I take just as much care as ever

I get sudden feelings of panic:

- ☐ Very often indeed
- ☐ Quite often
- ☐ Not very often
- ☐ Not at all

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 physicians at the Center. I authorize any holder of medical information about me to release to the Health Financial administration and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT NAME ……

PATIENT'S SIGNATURE……

DATE ……/……/……..

Patient Financial Agreement

Dear Patient:
As a service to our patients, our office accepts assignment of most major medical plans. However, in the current managed care environment, reimbursement for certain services has been increasingly difficult to obtain. In addition, most in-office procedures now require pre-certification or referral. In an effort to continue to give our patients excellent, yet affordable care, we ask that you take time to read and sign the following agreement. This will enable us to continue to submit insurance claims on behalf of our patients.

• I understand that I must have a current referral for every office visit and that it is my responsibility to obtain referrals from my PCP, according to the guidelines of my plan.

• I understand that copayments must be paid at the time of service.

• I understand that Dr. Mauskop has agreed to accept assignment from my insurance carrier for services rendered in the office; however, payment for services is ultimately my responsibility.

• I understand that the service (CPT Code#.....) performed by the Doctor may not be covered under Medicare and/or my insurance carrier. If it is not a covered service, I agree to remit payment in full.

Patient's Name……

Patient's Signature ……..

Date ……../……./…….

HIPPA 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.

Heathcare 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. This situations include: us 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 ok Department of health and Human services to investigate or determinate 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 tour 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 heath 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 alternatives 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.

Complains:

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:……..

Signature:……

Date:…../……/…….