

# New Patient Intake Form

DATE NAME DOB AGE

ADDRESS:

PRIMARY PHONE NUMBER:

SECONDARY PHONE NUMBER:

E-MAIL ADDRESS:

RACE:  African-American  Asian  Caucasian  Hispanic African-American  Hispanic Caucasian

 other

SEX:  Female  Male Height Weight

**Please provide your Health Insurance information:**

Insurance Carrier Name:

Insurance Plan Name:

Group ID:

Member ID:

Phone Number:

Mailing Address:

**Prescription Insurance Name** *if different than above*

RxBIN:

RxPCN:

RxGRP:

**Please provide the name, address, phone, and fax of your Referring Provider**

Name Phone Number Fax Number

Address/Location

**Please list your Primary Care Physician below:**

Name Phone Number Fax Number

Address/Location

**Please list any neurologists and/or headache specialists who you have seen for your headaches:**

**1.**

Name Phone Number

Address/Location

**2.**

Name Phone Number

Address/Location

**3**.

Name Phone Number

Address/Location

Where and when was your most recent Brain MRI done? *Please include location and approximate date*

Please provider the **name, location, and phone number** of the pharmacy where you would like your prescriptions filled.

**Headache - New Patient Intake Questionnaire**

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in

understanding problems that you may have. Please answer every question to the best of your ability.

1. In the past year, approximately how often did you have headaches each month?

 I did not have headaches in the past year

 <1 day per month

 1-4 days per month

 5-9 days per month

 10-14 days per month

 15 or more days per month

**2 a.** How old were you when you had your first headache? years old

**b.** How old were you when your most **severe** type of headache started? years old

1. Considering your headaches, please answer how the following statements describe your pain and other symptoms. **(**If you have just one type of headache, answer the questions regarding the “Most Severe Type” only.)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Most severe type** | **Second most severe type** | **Other types** |
| a. The pain is worse on | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely |
| just one side | ( ) Less than half the time | ( ) Less than half the time | ( ) Less than half the time |
|  | ( ) Half the time or more | ( ) Half the time or more | ( ) Half the time or more |
|  |  | ( ) Only one type of headache | ( ) Don’t have other types |
| b. The pain is pounding, | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely |
| pulsating or throbbing | ( ) Less than half the time | ( ) Less than half the time | ( ) Less than half the time |
|  | ( ) Half the time or more | ( ) Half the time or more( ) Only one type of headache | ( ) Half the time or more( ) Don’t have other types |
| c. The pain has moderate | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely |
| or severe intensity | ( ) Less than half the time | ( ) Less than half the time | ( ) Less than half the time |
|  | ( ) Half the time or more | ( ) Half the time or more | ( ) Half the time or more |
|  |  | ( ) Only one type of headache | ( ) Don’t have other types |
| d. The pain is made | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely |
| worse by routine activities | ( ) Less than half the time | ( ) Less than half the time | ( ) Less than half the time |
| such as walking or | ( ) Half the time or more | ( ) Half the time or more | ( ) Half the time or more |
| climbing stairs |  | ( ) Only one type of headache | ( ) Don’t have other types |
| e. You feel nauseated or | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely |
| sick to your stomach | ( ) Less than half the time | ( ) Less than half the time | ( ) Less than half the time |
|  | ( ) Half the time or more | ( ) Half the time or more | ( ) Half the time or more |
|  |  | ( ) Only one type of headache | ( ) Don’t have other types |
| f. Light bothers you (more | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely |
| than when you do not | ( ) Less than half the time | ( ) Less than half the time | ( ) Less than half the time |
| have headaches) | ( ) Half the time or more | ( ) Half the time or more | ( ) Half the time or more |
|  |  | ( ) Only one type of headache | ( ) Don’t have other types |
| g. Sound bothers you | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely | ( ) Never ( ) Rarely |
| (more than when you do | ( ) Less than half the time | ( ) Less than half the time | ( ) Less than half the time |
| not have headaches) | ( ) Half the time or more | ( ) Half the time or more | ( ) Half the time or more |
|  |  | ( ) Only one type of headache | ( ) Don’t have other types |

1. How long does your usual headache last if not treated?

 <4 hours  4-24 hours  2-7 days  more than 7 days  I always treat

1. On average in the past two months how often have you had to take an acute medication (such as Excedrin, Aleve, Ibuprofen or a prescription medication for a headache or any other acute pain?

 I did not take any acute medication in the past 2 months

 <1 day per week  3 days per week

 1-2 days per week  4-6 days per week

 I have to take some acute medicine every day of the week to decrease my pain

1. Check any of the following symptoms you have experienced around the time of your headache:

 numbness/tingling

 weakness on one side

 weak all over

 slurred speech

 dizziness

 ear ringing

 problems walking

 decreased level of consciousness

 trouble speaking

1. Over the past year, how often have you seen things like visual spots, stars, lines, flashing lights, zigzag lines, or “heat waves” around the time of your headaches?

 Never  Rarely  Less than half the time  Half the time or more  I don’t know

1. If you do have visual symptoms, how long does it last? min

 I don’t have visual symptoms

1. Over the past year, how often have you had a feeling of numbness or tingling in any part of your body or face around the time of your headache?

 Never  Rarely  Less than half the time  Half the time or more  I don’t know

1. If you do have numbness/ tingling, how long does it last? min

 I don’t have numbness/ tingling

1. When you have headaches how often is the pain severe?

 Never  Rarely  Sometimes  Very Often  Always

1. How often do headaches limit your ability to do usual daily activities including household work, occupational work, school, or social activities?

 Never  Rarely  Sometimes  Very Often  Always

1. When you have a headache how often do you wish you could lie down?

 Never  Rarely  Sometimes  Very Often  Always

1. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

 Never  Rarely  Sometimes  Very Often  Always

1. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

 Never  Rarely  Sometimes  Very Often  Always

1. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

 Never  Rarely  Sometimes  Very Often  Always

**17** a. Would you say that you are physically more active, less active, or about as active as other people your age?

 More active  Less active  About as active

b. Is that [a lot more or a little more/a lot less or a little less] active?

 a lot more  a little more  a lot less  a little less

1. **How often do you experience increased pain or an unpleasant sensation *on your skin* during your most severe type of headache when you are doing any of the following activities?** (Please check one box.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Never** | **Rarely** | **Less Than Half the****Time** | **Half the Time****or More** | **Does Not Apply to Me** |
| Combing your hair |  |  |  |  |  |
| Pulling your hair back (such as in a ponytail) |  |  |  |  |  |
| Shaving your face |  |  |  |  |  |
| Wearing eyeglasses |  |  |  |  |  |
| Wearing contact lenses |  |  |  |  |  |
| Wearing a necklace |  |  |  |  |  |
| Wearing tight clothing |  |  |  |  |  |
| Taking a shower (when shower water hits your face) |  |  |  |  |  |
| Resting your face or head on a pillow |  |  |  |  |  |
| Exposure to heat (such as when cooking or when washing your face with hot water) |  |  |  |  |  |
| Exposure to cold (using an ice pack, washing with cold water) |  |  |  |  |  |

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **Several Days** | **More than half the days** | **Nearly every day** |
| Little interest or pleasure in doing things |  |  |  |  |
| Feeling down, depressed, or hopeless |  |  |  |  |
| Trouble falling or staying asleep, or sleeping too much |  |  |  |  |
| Feeling tired or having little energy |  |  |  |  |
| Poor appetite or overeating |  |  |  |  |
| Feeling bad about yourself – or that you are a failure or have let yourself or your family down |  |  |  |  |
| Trouble concentrating on things such as 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 have been moving around a lot more than usual |  |  |  |  |
| Thoughts that you would be better off dead, or of hurting yourself in some way |  |  |  |  |

1. Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one of more of the boxes to the right that a) happened to you personally b) you witnessed it happen to someone else c) you learned about it happening to someone close to you d) you’re not sure e) doesn’t apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | Happened to Me | Witnessed it | Learned about it | Not Sure | Does not Apply |
| A | Natural disease (ex: flood, hurricane, tornado) |  |  |  |  |  |
| B | Fire or explosion |  |  |  |  |  |
| C | Transportation accident (ex: car accident, boat accident, plane crash, etc.) |  |  |  |  |  |
| D | Serious accident at work, home, or during recreational activity |  |  |  |  |  |
| E | Exposure to toxic substance (ex: dangerous chemicals, radiation) |  |  |  |  |  |
| F | Physical assault (ex: being attacked, hit, slapped, kicked, beaten up) |  |  |  |  |  |
| G | Assault with a weapon (ex: shot, stabbed, threatened with a knife, gun, bomb, etc.) |  |  |  |  |  |
| H | Sexual assault (ex: rape, attempted rape, made to perform any type of sexual act through force or threat of harm) |  |  |  |  |  |
| I | Other unwanted or uncomfortable sexual experience |  |  |  |  |  |
| J | Combat or exposure to a war-zone (in the military or as a civilian) |  |  |  |  |  |
| K | Captivity (ex: being kidnapped, abducted, held hostage, prisoner of war) |  |  |  |  |  |
| L | Life threatening illness or injury |  |  |  |  |  |
| M | Severe human suffering |  |  |  |  |  |
| N | Sudden, violent death (ex: suicide or homicide) |  |  |  |  |  |
| O | Sudden expected death of someone close to you |  |  |  |  |  |
| P | Serious injury, harm, or death you caused to someone else |  |  |  |  |  |
| Q | Any other very stressful event or experience: |  |  |  |  |  |

1. How many upsetting or traumatic events have you had in your lifetime?

□ **0** □ **1** □ **2** □ **3** □ **4** □ **>5**

1. What was the most upsetting or most significant or most traumatic event you’ve experienced?
2. What was the date of this most significant traumatic event?
3. How old were you at the time of this event? (if used more than one, use the event that was most upsetting/significant)
4. Keeping in mind your most significant traumatic or stressful event, please indicate how much you have been bothered by the following statements, by circling a number from 1 - 5 with the following scale:

**1 = not at all 2= a little bit 3 = moderately 4 = quite a bit 5 = extremely**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| A | Repeated, disturbing memories, thoughts or images of the stressful experience | 1 | 2 | 3 | 4 | 5 |
| B | Repeated, disturbing dreams of the stressful experience | 1 | 2 | 3 | 4 | 5 |
| C | Suddenly acting or feeling as if the stressful experience were happening again (as if you were re-living it) | 1 | 2 | 3 | 4 | 5 |
| D | Feeling very upset when something reminded you of the stressful experience | 1 | 2 | 3 | 4 | 5 |
| E | Having physical reactions (ex: heart pounding, trouble breathing, sweating) when something reminded you of the stressful event | 1 | 2 | 3 | 4 | 5 |
| F | Avoiding thinking about or talking about the stressful experience or avoid having feeling related to it | 1 | 2 | 3 | 4 | 5 |
| G | Avoiding activities or situations because they remind you of the stressful experience | 1 | 2 | 3 | 4 | 5 |
| H | Trouble remembering important parts of the stressful experience | 1 | 2 | 3 | 4 | 5 |
| I | Loss of interest in activities that you used to enjoy | 1 | 2 | 3 | 4 | 5 |
| J | Feeling distant or cut-off from other people | 1 | 2 | 3 | 4 | 5 |
| K | Feeling emotionally numb or being unable to have feelings for those close to you | 1 | 2 | 3 | 4 | 5 |
| L | Feeling as if your future will be cut short | 1 | 2 | 3 | 4 | 5 |
| M | Trouble falling asleep or staying asleep | 1 | 2 | 3 | 4 | 5 |
| N | Felling irritable or having angry outbursts | 1 | 2 | 3 | 4 | 5 |
| O | Having difficulty concentrating | 1 | 2 | 3 | 4 | 5 |
| P | Being super alert, or watchful, or on-guard | 1 | 2 | 3 | 4 | 5 |
| Q | Feeling jumpy or easily startled | 1 | 2 | 3 | 4 | 5 |

**26a.** Please circle any medication you have either 1) used for headache or 2) used for a reason other than headache.

|  |  |  |
| --- | --- | --- |
| **Medication** | **Have used for****headache** | **Used for a reason other****than headache** |
| **Anti-Depressant Medications** |  |  |
| Amitriptyline (Elavil) |  |  |
| Nortriptyline (Pamelor) |  |  |
| Venlafaxine (Effexor) |  |  |
| Duloxetine (Cymbalta) |  |  |
| **Blood Pressure/ Heart Medications** |  |  |
| Propranolol (Inderal) |  |  |
| Metoprolol (Lopressor/Toprol) |  |  |
| Timolol (Blocadren) |  |  |
| Lisinopril (Prinivil, Zestril) |  |  |
| Atenolol (Tenormin) |  |  |
| Verapamil (Calan, Covera, Isiptin) |  |  |
| Norvasc (Amlodipine) |  |  |
| **Migraine/ Seizure Medications** |  |  |
| Valproic Acid (Depakote) |  |  |
| Topiramate (Topamax) |  |  |
| Gabapentin (Neurontin) |  |  |
| Levetiracetam (Keppra) |  |  |
| Pregabalin (Lyrica) |  |  |
| Clonazepam (Klonopin) |  |  |
| Lamotrigine (Lamictal) |  |  |
| Zonisamide (Zonnegran) |  |  |
| Carbamazepine (Tegretol) |  |  |
| Oxcarbamazepine (Trileptal) |  |  |
| Phenytoin (Dilantin) |  |  |
| **Muscle Relaxants** |  |  |
| Botulinum toxin (Botox) |  |  |
| Baclofen (Lioresal) |  |  |
| Cyclobenzaprine (Flexeril) |  |  |
| **Vitamins and Supplements** |  |  |
| Melatonin |  |  |
| Vitamin B2 (Riboflavin) |  |  |
| Magnesium Oxide |  |  |
| Petadolex (Butterbur) |  |  |
| Co-Enzyme Q 10 |  |  |
| ***CGRP Medications*** |  |  |
| Vyepti (eptinezumab) |  |  |
| Aimovig (erenumab) |  |  |
| Ajovy (fremanezumab) |  |  |
| Emgality (galcanezumab) |  |  |

**26b.** Please circle any medication you have either 1) used for headache or 2) used for a reason other than headache.

|  |  |  |
| --- | --- | --- |
| **Medication** | **Have used for****headache** | **Have used for a reason****other than headache** |
| **Over the Counter Acute Treatment Medications** |  |  |
| Aleve/ Anaprox/ Naprosyn (naproxen) |  |  |
| Advil/ Motrin (ibuprofen) |  |  |
| Excedrin/ Excedrin Migraine (acetaminophen+asprin+caffeine) |  |  |
| Orudis/Oruvail (ketoprofen) |  |  |
| Tylenol (acetaminophen) |  |  |
| **Acute Prescription Medications** |  |  |
| Amerge tablets (naratriptan) |  |  |
| Axert (almotriptan) |  |  |
| Frova tablets (frovatriptan) |  |  |
| Imitrex (sumatriptan) |  |  |
| Imitrex Nasal Spray (sumatriptan) |  |  |
| Imitrex STAT Injection (sumatriptan) |  |  |
| Maxalt tablets or MLT wafer (rizatriptan) |  |  |
| Relpax tablets (eletriptan) |  |  |
| Zomig tablet or ZMT wafer (zolmitriptan) |  |  |
| Zomig nasal spray (zolmitriptan) |  |  |
| Bellegral-S/ Cafergot (ergotamine) |  |  |
| Migranal nasal spray (dihydroergotamine) |  |  |
| DHE-45 Injection (dihydroergotamine) |  |  |
| Midrin/ Duradrin (Isomeheptene + dichloralphenazone + acetaminophen |  |  |
| Demerol (oral or injected meperidine) |  |  |
| Fiorinal/Fioricet (butalbital + caffeine + acetaminophen with or without codeine) |  |  |
| Darvocet |  |  |
| Tylenol with codeine |  |  |
| Celebrex |  |  |
| Vicodin or Vicoprofen |  |  |
| Phrenilin (butalbital + acetaminophen) |  |  |
| Stadol NS (butorphanol) |  |  |
| Toradol (ketorolac) |  |  |
| Nurtec (rimegepant) |  |  |
| Ubrelvy (ubrogepant) |  |  |

1. Please circle any medications or treatments that you have used that were NOT listed above**.**

Imipramine Protriptyline Doxepin Fluoxetine Fluvoxamine Mirtazapine Baclofen Carisoprodol Prochlorperazine Olanzapine

Trimethobenzamide Phenelzine

Nadolol Amlodipine Nisoldipine Nimodipine Pizotifen Cyproheptadine Diazepam Alprazolam Chlordiazepoxide Methysergide Metoclopramide Aspirin

Oxygen Meclofenmate

Desipramine Amoxapine Venlafaxine Paroxetene Buproprion Amoxapine Methocarbamol Orphenadrine Risperdone Zirprasidone Montelukast Tranylcypromine Lidocaine nasal drops Diltiazem

Nifedipine Flunarazine Diphenhydramine Hydroxyzine Lorazepam Chlorazepate Clonidine Celecoxib Promethazine Anacin Methergine Ketoprofen

Clomipraimine Maprotiline Sertraline Citalopram Nefazodone Tizanidine Cyclobenzaprine Lithium Quitaiapine Perphenazine Zafirlukast Isocaboxazid Piroxicam Tiagabine Nicardipine Dotarazine Meclizine Phenobarbital Clonazepam Temazepam Feverfew Rofecoxib Indomethacin Diclofenac

Steroids (ex: prednisone, depo medrol) Greater Occipital Nerve Block Memantine

Please note the medication(s) circled above and the reason you did not continue them (did not work, side effects). Please be as specific as possible and include dosages.

## The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all the questions.

1. During the past month, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.) hours of sleep per night

## For each of the remaining questions, check the one best response. Please answer all questions.

1. During the past month, how often have you had trouble sleeping because you...
	1. Can NOT get to sleep within 30 minutes

□ Not during the past month □ < 1 time per week □ 1-2 times per week □ 3 or more times per week

* 1. Wake up in the middle of the night or early morning

□ Not during the past month □ < 1 time per week □ 1-2 times per week □ 3 or more times per week

* 1. Have to get up to use the bathroom

□ Not during the past month □ < 1 time per week □ 1-2 times per week □ 3 or more times per week

* 1. Can NOT breathe comfortably

□ Not during the past month □ < 1 time per week

□ 1-2 times per week □ 3 or more times per week

* 1. Cough or snore loudly

□ Not during the past month □ < 1 time per week □ 1-2 times per week □ 3 or more times per week

* 1. Feel too cold

□ Not during the past month □ < 1 time per week □ 1-2 times per week □ 3 or more times per week

* 1. Feel too hot

□ Not during the past month □ < 1 time per week □ 1-2 times per week □ 3 or more times per week

* 1. Had bad dreams

□ Not during the past month □ < 1 time per week □ 1-2 times per week □ 3 or more times per week

* 1. Have pain

□ Not during the past month □ < 1 time per week □ 1-2 times per week □ 3 or more times per week

* 1. Other reasons (s), please describe here:

□ Not during the past month □ < 1 time per week □ 1-2 times per week □ 3 or more times per week

**More Questions about you:**

I am:

 single  married

 separated  divorced

 widowed

I have (number of) children.

**My highest level of completed education is:**

**Please list any non-medication allergies:**

**Please list any medical problems in your family & note who in the family suffers with the disorder: (such as mom, dad etc.)**

 less than high school

 high school graduate

 college graduate

 post-graduate or doctoral degree

**Please check the box that most accurately reflects your total household income:**

 < $20,000  $20,000 – $50,000

 $50,000 - $100,000  >$100,000

**My occupation is:**

**Please list any medical diagnoses you have:**

**How much caffeine do you consume daily?**

**How much alcohol do you consume?**

 Every day

 5 to 6 times a week

 3 to 4 times a week

 twice a week

 once a week

 2 to 3 times a month

 once a month

 3 to 11 times in the past year

 1 or 2 times in the past year

**Please note any street drug(s) you use:**

**Please list any surgeries you have had:**

**Please list any allergies to medications:**

**Please list any family members who have complained of headaches** (even if not as severe as your headaches.)

 mother  father  brother  sister  daughter  son  uncle on mother’s side  uncle on father’s side  aunt on mother’s side

 aunt on father’s side  grandmother on mother’s side  grandfather on mother’s side

 grandmother on father’s side  grandfather on father’s side cousin’s mother’s side

cousin father’s side

 other

CURRENT MEDICATIONS

Please list **all** medications you are currently taking including the dose & frequency

Please list **all** vitamins and supplements you are currently taking including the dose & frequency

**THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORD NAME OF PERSON COMPLETING THIS FORM:**

***Signature Printed Name Date/Time***

**RELATIONSHIP TO PATIENT:**