Account# _____

PATIENT REGISTRATION

Please answer all questions completely. **PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED**

Date_____ ☐**New** ☐**Update**

Name_____ Date of Birth _____ ☐ Male ☐ Female
Last First Middle

Home Address_____

City/State/Zip _____

Phone (_____) _____

Cell (_____) _____

Patient's Soc. Sec. # _____

Driver License No/State _____

Race __White/Caucasian __ Black or African American __ Asian __ American Indian __ Native Hawaiian or Other Pacific __ Decline to State

Ethnicity __ Hispanic or Latino __ Not Hispanic or Latino __ Decline to State

Primary Language Spoken _____

Employer_____ Employer's Address_____
Who is your Primary Care Physician? _____Referring Physician? _____

PATIENT'S E-MAIL ADDRESS _____

Financially Responsible Party (subscriber info)

If other than self _____Relationship _____

Address _____ Phone (___)_____
Number Street City

Patient's Primary Insurance _____ **Subscriber's Social Security #**_____

Subscriber ID #_____ **Subscriber's Group ID#** _____**DOB** _____/_____/_____

Patient's Secondary Insurance _____ **Subscriber's Social Security #**_____

Subscriber ID #_____ Group **ID#** _____ **DOB** _____/_____/_____

Subscriber to Secondary Insurance _____**Relationship to Patient**_____

Emergency contact_____ Relationship _____
Last Name First Middle

☐ **Please check box if authorized to release appointment/medical information.**

Address _____ Phone (_____)_____
Number Street City

I have read and understand all of the above and hereby give my consent for medical treatment.

I understand that I am responsible for my bill.

I hereby authorize The Neurology Center to release medical and/or billing information to my insurance company.

_____ _____

Patient's Signature **Date**

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Patient Name: _____

PERMISSION TO FURNISH MY MEDICAL INFORMATION

1. FURNISH TO RELATIVES AND/OR PERSONAL ASSOCIATES

I hereby give my consent to The Neurology Center to furnish medical information about me (e.g., blood test results, other test results, doctor's instructions, etc.) in the event I am not immediately available.

Approved Person(s)	Relationship to Patient
_____	_____
_____	_____
_____	_____

- ❑ I hereby authorize The Neurology Center to disclose medical information in the purpose to contact me with routine results and to remind me of my future appointments. You may email, send text messages and or leave this information on my answering machine.
- ❑ I hereby instruct The Neurology Center to furnish information **only** to me. In this instance, I understand you will leave a message for me to call the office if I am not immediately available.
- ❑ Other special instructions regarding furnishing my medical information: _____

_____

_____

X_____ _____ _____

Signature **Date** **Relationship to Patient**

2. FURNISH TO PHYSICIANS OR OTHER MEDICAL PROVIDERS

I understand that The Neurology Center will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc) **about me with my Primary Care Physician and/or the Provider or entity that referred me to The Neurology Center.**

In addition, I hereby give my consent to The Neurology Center to furnish and/or discuss my medical information with the following additional Medical Providers or Entity(ies)

Providers Name	Phone Number	City
_____	_____	_____
_____	_____	_____
_____	_____	_____

X_____ _____ _____

Signature **Date** **Relationship to Patient**

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THE HEADACHE CENTER OF SOUTHERN CALIFORNIA

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

PATIENT NAME: _____ **TODAY'S DATE**: _____

Date of Birth: _____ Age: _____

Referring Physician: _____

What is your primary language spoken? _____

How do you prefer to receive information about your diagnosis? Verbal___ Written___ Pictures___

I am: Right handed _____ Left handed _____ Ambidextrous _____

Current Height _____ Current Weight _____

Allergies:
Please list any allergies to medications: _____

Are you allergic to X-ray dye? _____

Are you allergic to shellfish? _____

Social History:
Marital Status: Married ____ Single____ Divorced _____ Widowed _____

Education Completed: (years) _____

Occupation: _____

Do you exercise regularly? Yes____ No____
If so what do you do? _____

Habits:
Check any of the following that you have used and state the amount:

- ❑ Caffeine How much per day? _____
- ❑ Alcohol How much per day? _____
- ❑ Tobacco How much per day? _____

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THE HEADACHE CENTER OF SOUTHERN CALIFORNIA

Patient Name: _____

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

Review of Systems

Check boxes if you are having any of these symptoms; write in details:

Constitutional
- □ Chills
- □ Fatigue
- □ Changes in Weight

Eyes
- □ Double vision
- □ Eye Pain
- □ Blurred vision

Ears, Nose and throat
- □ Hearing loss
- □ Ringing
- □ Dizziness
- □ Sore throat

Cardiovascular
- □ Ankle swelling
- □ Night sweats
- □ Chest Pain or Pressure
- □ Skipped beats
- □ Blackouts

Respiratory
- □ Cough
- □ Shortness of breath
- □ Hyperventilation

Gastrointestinal
- □ Abdominal Pain
- □ Appetite loss
- □ Blood in stool
- □ Constipation
- □ Diarrhea
- □ Nausea
- □ Vomiting

Hematologic/Lymphatic
- □ Easy bruising or bleeding
- □ Anemia

Musculoskeletal
- □ Joint stiffness
- □ Joint swelling
- □ Joint Limitation
- □ Joint pain
- □ Neck pain
- □ Back pain

Genitourinary
- □ Blood in urine
- □ Burning with urination
- □ Hesitancy
- □ Night time frequency
- □ Difficulty with urination

Skin/Breast
- □ Rashes
- □ Nipple discharge

Endocrine
- □ Intolerant of heat or cold
- □ Excessive urination
- □ Excessive hunger
- □ Increased thirst

Allergic/Immunologic
- □ Allergies to medication, Iodine, shellfish,

Neurological
- □ Difficulty with speech
- □ Impaired memory
- □ Confusion
- □ Headaches
- □ Seizures
- □ Blackouts
- □ Fainting
- □ Trouble swallowing
- □ Arm pain
- □ Leg pain
- □ Weakness or paralysis
- □ Tremors
- □ Incoordination
- □ Uncontrolled movements
- □ Stroke
- □ Imbalance
- □ Numbness
- □ Tingling

Psychiatric
- □ Mood swings
- □ Depression
- □ Anxiety
- □ Memory
- □ Hallucinations

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THE HEADACHE CENTER OF SOUTHERN CALIFORNIA

Patient Name: _____

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

Past Medical History

Check if you have had any of these problems. Give details.

- □ Angina
- □ Asthma
- □ Blindness, part or full
- □ Cancer
- □ Depression
- □ Diabetes
- □ Dizziness
- □ Double vision
- □ Fainting
- □ Head trauma
- □ Headache
- □ Hearing problem
- □ Heart attack
- □ Heart failure
- □ Hepatitis
- □ Herniated disc
- □ High blood pressure
- □ High cholesterol
- □ Irregular heart beats
- □ Nervous breakdown
- □ Numbness
- □ Polio
- □ Psychiatric conditions
- □ Sciatica
- □ Seizures (epilepsy)
- □ Speech problems
- □ Stroke
- □ Swallowing problems
- □ Ulcers
- □ Venereal infections
- □ Vertigo
- □ Walking problems

Have you had any of these tests? Give details.

- □ Angiogram of the brain
- □ CAT scan
- □ EEG (brain wave test)
- □ EMG (nerve-muscle test)
- □ Spinal tap
- □ Skull X-ray
- □ Spine X-ray
- □ Magnetic Resonance (MRI)

Surgical Procedures – List chronologically

Operations	**Hospital & City**	**Date**
1.		
2.		
3.		

Other Hospitalizations Or Other Medical Problems

1.	
2.	
3.	
4.	

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THE HEADACHE CENTER OF SOUTHERN CALIFORNIA

Patient Name: _____

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

Family History:
Have any of your relatives has any of the following? If yes, indicate relationship (e.g., father):

Check if positive	**Relationship**
□ Alcoholism	_____
□ Cancer	_____
□ Diabetes	_____
□ Heart Disease	_____
□ Mental Illness	_____
□ Migraine	_____
□ Seizures	_____
□ Stroke	_____
□ Tuberculosis	_____

Are there any other diseases that run in the family?_____

Medications: Please list all of the medications you are currently taking. Including aspirin, birth control pills, hormones, water pills, sleeping pills, tranquilizers, vitamins, etc.

Medication	**Dosage**	**How often taken?**	**For how long have you taken it?**

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THE HEADACHE CENTER OF SOUTHERN CALIFORNIA

Patient Name: _____

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

1. When did you first start having any kind of headache? _____

2. How frequent were your headaches initially? _____

3. When did you first start having any kind of severe headache? _____

4. How many headaches of any kind do you experience on average per month in the last year? _____

5. How long have they been this frequent? _____

6. On average how many days a month are you completely headache **FREE (no pain)**? _____

7. On average how many moderate to severe headaches do you experience per month? _____

8. How long do your moderate to severe headaches typically last? (Circle)
   No more than: Minutes 3 hours 4 hours 24 hours 2days 1 week or longer

8. How painful are your headaches? (1 is mild and 10 is severe and disabling) (Circle)
   1 2 3 4 5 6 7 8 9 10

9. Where are your headache typically located? (Check all that apply)

Behind the eye	___Right ___ Left	Temple	___Right ___ Left
Forehead	___Right ___ Left	Side of the head	___Right ___ Left
Back of head	___Right ___ Left	Neck	___Right ___ Left

   Whole head _____

10. How would you describe your headache character?
    Throbbing Stabbing Pressure Burning Tightness Dull Sharp Other

11. Do any of the following symptoms occur before or during your headaches? (Circle all that apply)
    Nausea Vomiting Sensitive to light Sensitive to noise Sensitive to smell
    Blurred or Double vision Loss of vision Flashing, sparkling, colored lights in eyes
    Eye lid droop Eye tearing Dizziness Difficulty concentrating
    Speech difficulty Numbness/tingling Weakness of face, arm or leg
    Other _____

12. Do any of the following trigger your headache or make them worse? (Circle all that apply)
    Exercise Increased stress Lack of sleep Weather change/Storm Bright light Loud noise Fatigue
    Missing a meal Strenuous activity Certain smells or perfume Coughing/sneezing Bending over
    Sexual activity Dehydration Eye strain Caffeine/Lack of Caffeine Alcohol: wine, beer, or liquor
    Foods: chocolate, cheese, MSG, gluten or other _____

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THE HEADACHE CENTER OF SOUTHERN CALIFORNIA

Patient Name: _____

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

13. If you are female, did or do your headaches change with the following? (Circle all that apply)
    Menstrual cycle Birth control Pregnancy Menopause Other hormonal medications

14. Do your headaches ever awaken you in the middle of the night or present upon awakening in the morning? (Circle)
    Night: Occasionally Often
    Morning: Occasionally Often

15. Do any of your family members have headaches? No Yes If yes, who? _____

16. Do you have a history of:
    Anxiety Depression Trouble sleeping Irritable Bowel Syndrome Fibromyalgia Chronic Fatigue
    Seizure Disorder Bipolar Disorder Restless leg Syndrome

17. List the testing you have had for your headaches (MRI, CT, spinal puncture): If yes, please provide the facility name:

    _____

    _____

    _____

18. How many days a week do you use medication for acute treatment of headache (prescription or over the counter)? _____

19. Which medication(s):

    _____

    _____

    _____

20. How long have you been using that amount of medication for acute treatment? _____

21. How many times in the **last year** did you go to the ER because of headaches?
    0 1-2 3-4 5+

Did you need any assistance filling out this form? Yes _____ No _____

Signature _____ Date _____

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THE HEADACHE CENTER OF SOUTHERN CALIFORNIA

Patient Name: _____

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

Medications you have tried

ABORTIVE AGENTS		PROPHYLACTIC AGENTS	
Over the counter		**Anti-Depressants**	
Ibuprofen	Aleve – naproxen	Elavil- amitriptyline	
Excedrin	Tylenol	Pamelor- nortriptyline	
BC Powder		Vivactil- protriptyline	
		Prozac- fluoxetine	
Triptans		Paxil- paroxetine	
Imitrex- sumatriptan (pill, nasal spray, or injection)		Effexor- Venlafaxine	
Treximet – Imitrex/naproxen		Cymbalta - Duloxatine	
Maxalt- rizatriptan		**Seizure Medications**	
Relpax- eletriptan		Topamax- topiramate	
Zomig- zolmitriptan (pill or nasal spray)		Zonegran- zonisamide	
Axert- almotriptan		Depakote- divalproex or valproic acid	
Amerge- naratriptan		Neurontin- gabapentin	
Frova- frovatriptan		Lamictal- lamotrigine	
		Lyrica- pregablin	
Other Pain Relievers			
Fioricet- butalibital/acetaminophen/caffeine		**Blood pressure medication**	
Fiorial- butalibital/aspirin/caffeine		Inderal- propranolol	
DHE- dihydroergotoamine		Verapamil	
Midrin		Atacand-candesartan	
		Atenolol, metoprolol, nadolol, timolol	
Narcotics			
Norco, Lortab, Percocet		**Botox Injections**	
Oxycodone, Hydrocodone, Dilaudid, Morphine			
Tylenol with Codeine		**Natural Supplements**	
		Riboflavin	Butterbur
Other NSAID's (Non-Steroidal Anti-inflammatories)		Magnesium Co Q 10	
Ketoprofen	Relafen		
Diclofenac (Cambia or Zipsor)	Meloxicam	**Procedures:**	
		Accupuncture	Chiropractor
Muscle Relaxants		Cefaly band	Massage
Norflex	Zanaflex	Occipital Nerve Block	SphenoCath
Flexeril-cyclobenzaprine	Baclofen	Transcranial Magnetic Stimulation Device	

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THE HEADACHE CENTER OF SOUTHERN CALIFORNIA

Patient Name: _____

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

Is there any additional information you would like to add about your headaches?

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THE HEADACHE CENTER
OF SOUTHERN CALIFORNIA

Name: _____

DOB: _____Age: _____

Weight: _____Height: _____

Gender ☐ Female ☐ Male

Do you snore?	**Yes ____**	**No ____**
Do you feel tired, fatigued or sleepy during the day?	**Yes ____**	**No ____**
Has anyone observed you stop breathing while you sleep?	**Yes ____**	**No ____**
Do you nap during the day?	**Yes ____**	**No ____**

Do you have any of the following?

Heart Disease	□ Yes	□ No
History of Stroke	□ Yes	□ No
High Blood Pressure	□ Yes	□ No
Depression	□ Yes	□ No
Morning Headaches	□ Yes	□ No
Trouble with Memory Or Concentration	□ Yes	□ No

Sleep Orders
For Office Use Only

- □ **Sleep Consult**
- □ **PSG**
- □ **CPAP Titration Study**
- □ **Patient not a candidate for sleep assessment**

_____

Physician Signature

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