QUESTIONNAIRE FOR NEW HEADACHE PATIENTS

DIANE COUNCE, M.D.

Board Certified Neurologist
Neurodiagnostic Facility & Clinic
(EEG, EMG, NCS, RNS, THERAPEUTIC BOTOX)

Before you can be seen, please have this form filled out in its entirety. Accuracy is of utmost importance in order to deliver appropriate care. This document is confidential and will become a part of your medical record. ***You will not be seen unless this form is filled out and signed.***

Name: _____ Date: _____

Age: _____ DOB: _____

Address:_____
Street and apt# City Zip

Referring Physician: _____ Family Physician: _____

Pharmacy Name and Number: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS RELATED TO HEADACHES:

1. **Where** are your headaches (HAs) usually located (i.e. generalized, frontal, temples, top of head, back of head, right side, left side, band around the head, changes locations, etc.)?_____
_____

2. How would you describe the **pain** (i.e. throbbing, pounding, blinding, sharp, stabbing, sticking, steady, dull, aching, boring, pressure, burning, etc.)
_____

3. Rate your average HA on a scale of **1-10** (1 = minimal pain, 10 = severe)_____

4. Approximately **how long** do your HAs last**?** _____

5. What **date** did your headaches **begin**? _____

6. How many **days per month** do you have HAs? _____
    a. Mild ones? _____
    b. Severe ones? _____
    c. If more than 15 per month, when did this start? _____

7. What **time of day** do your HAs usually begin? _____

8. Have your HAs **worsened** over time? _____

NAME _____ DATE _____

9. Have you been able to identify any specific **triggers** for your HAs? _____
If yes, explain _____

10. Do you have any certain **food cravings** prior to the onset of your HAs?_____
If yes, explain _____

11. How much **caffeine** do you consume in an average day? _____
Does it worsen your headache_____

12. Do your HAs increase with **coughing** and/or **exertion**? _____

13. Do your HAs change with different **seasons**? _____

14. For female patients: Have you noticed any correlation between your HAs and **hormonal changes**? (changes in frequency and severity during ovulation and/or menstrual cycle) _____
Are you **pregnant** or have plans to become pregnant in the near future?_____
Have you had any **miscarriages**? _____

15. How is your **sleep**? _____

16. Do you experience an increase in your HAs when you get off of your **regular schedule** such as stay up late, sleep-in on the weekends, or skip meals?
_____

17. What have you found to **help** your headaches (sleep, ice, heat, medication, darkness)? _____

18. Do you have any type of **warning** (aura) that your HA is coming on? (sparkling lights, yawning, irritability, etc.) _____

19. Do you **wake up** from the HA pain? _____

20. If you have **vomiting** from the HA, is it at night or do you wake up from it? _____

21. Do you have these associated symptoms with HAs:

	Never	Rarely	Sometimes	Most times
Nausea	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐
Sensitivity to light	☐	☐	☐	☐
Sensitivity to sound	☐	☐	☐	☐
Sensitivity to smell	☐	☐	☐	☐
Sinus pressure	☐	☐	☐	☐

NAME _____ DATE _____

Associated symptoms, continued:

	Never	Rarely	Sometimes	Most times
Congestion	☐	☐	☐	☐
Runny nose	☐	☐	☐	☐
Watery eyes	☐	☐	☐	☐
Red eyes	☐	☐	☐	☐
Droopy eyelids	☐	☐	☐	☐
Numbness	☐	☐	☐	☐
Where? _____				
Tingling	☐	☐	☐	☐
Where? _____				
Weakness	☐	☐	☐	☐
Where? _____				
Dizziness	☐	☐	☐	☐
Spinning/movement	☐	☐	☐	☐
Passed out	☐	☐	☐	☐
Felt faint	☐	☐	☐	☐
Confusion	☐	☐	☐	☐
Thinking difficulty	☐	☐	☐	☐
Changes in vision	☐	☐	☐	☐
Describe _____				
Neck Pain	☐	☐	☐	☐
Neck stiffness	☐	☐	☐	☐

22. Do you have **TMJ** or jaw pain? _____

23. Do you see **flashes of light** when bending over?_____

24. How is your **mood**? _____

25. Does your **sleep change** due to HAs? _____

26. Do HAs cause **yawning**? _____

27. Does your hair and/or your skin become **sore to the touch** during or after a HA?____

28. Have you had a **CT (CAT) scan** of your head? _____

29. When? _____

30. What were the results? _____
_____

31. Have you had a **MRI** of your head? _____

NAME _____ DATE _____

32. When? _____

33. What were the results? _____
_____

Below are some questions that might help us in the diagnosis and treatment of your headaches. Answer only the questions that you feel comfortable answering. All information is kept confidential in compliance with HIPAA.

34. What is your marital status? _____

35. Did you have a pleasant childhood? _____

36. Are there any past or present issues with abuse?_____

37. Are you happy with your present job? _____

38. Is there currently an unusual amount of stress at home? _____

39. Do you have a strong support system consisting of family and friends? _____

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40. Have you had to go to the **ER** because of severe HA? _____

41. What did you receive? _____

42. What **other physicians** have you seen recently for your HAs? _____
_____

43. Do you take **over-the-counter medications**? If so, please list them:
_____
_____
_____

44. Have you had any **Head Trauma**? If so, please explain:_____
_____
_____

45. When was your last **eye exam**? _____

46. When was your last **dental exam**? _____

47. Have you had to miss **work, school or activities** due to your HAs? _____

NAME _____ DATE _____

48. Any other information related to your headaches: _____

_____

_____

ALL PATIENTS: Review the list of medications below. Circle any that you have tried, write down the dose if you can remember it, the side effects and whether or not it was effective.

Topamax
Depakote
Lamictal
Keppra
Neurontin
Lyrica
Zonegran
Vimpat
Atenolol/Metoprolol
Propranolol
Verapamil
Magnesium
Riboflavin
Feverfew
Lortab/Norco
Lorcet
Ultram/Tramadol
Percocet
Mepergan
Botox

Prozac
Paxil
Zoloft
Celexa
Lexapro
Effexor
Cymbalta
Elavil
Pamelor

Imitrex
Zomig
Amerge
Axert
Maxalt
Frova
Relpax
Treximet
DHE
Migranal
Cafergot
Ergomar
Midrin/Prodrin/Nodolor
Anaprox (Naprosyn)
Cambia
Zipsor
Toradol
Steroids
Stadol
Fiorinal
Fioricet
Periactin

Please list any other medications you have tried:

List any medical problems/diagnoses that you have had in the past or currently have:
Especially Mitral Valve Prolapse_____

_____

_____

_____

List any past surgeries and the approximate date:

_____

_____

_____

NAME _____ DATE _____

Do you have any drug allergies? Yes ____ No ____

If yes, please list:

_____

Please list all medications and the doses you are currently taking:

_____

_____

_____

_____

List any medical problems in your family:

Mother: _____

Father: _____

Sister: _____

Brother: _____

Daughter: _____

Son: _____

Other: _____

_____

_____

Smoking Status:

____Never ____Former ____Everyday ____Occasionally

How many packs per day: _____

How many years of smoking: _____

Marital Status: _____

Occupation: _____

Do you use alcohol? ____Yes ____No

If yes, what kind and how much: _____

Do you use illegal drugs? ____Yes ____No ____In the past

If yes, what kind and how much: _____

Do you use chewing tobacco? ____Yes ____No

If yes, how many times per day? _____

REVIEW OF SYSTEMS:

	YES	NO		YES	NO
DIZZINESS	☐	☐	APPETITE CHANGES	☐	☐
FAINTING	☐	☐	BOWEL CHANGES	☐	☐
BLACKOUTS	☐	☐	NAUSEA	☐	☐

NAME _____ DATE _____

REVIEW OF SYSTEMS, CONTINUED:

	YES	NO		YES	NO
MEMORY LOSS	☐	☐	ABDOMINAL PAIN	☐	☐
HEADACHES	☐	☐	VOMITING	☐	☐
IMBALANCE/FALLS	☐	☐	WEIGHT LOSS	☐	☐
PAIN	☐	☐	WEIGHT GAIN	☐	☐
WEAKNESS	☐	☐	FEVER	☐	☐
NUMBNESS	☐	☐	FATIGUE	☐	☐
CHEST PAIN	☐	☐	ANEMIA	☐	☐
CARDIAC PACEMAKER	☐	☐	SORES	☐	☐
SNORING	☐	☐	BRUISING	☐	☐
RESTLESSNESS IN LIMBS	☐	☐	COLD INTOLERANCE	☐	☐
DAYTIME SLEEPINESS	☐	☐	HEAT INTOLERANCE	☐	☐
BLURRY VISION	☐	☐	SHORTNESS OF BREATH	☐	☐
CROSSED EYES	☐	☐	COUGH	☐	☐
DIFFICULTY SWALLOWING	☐	☐	SUICIDE ATTEMPT	☐	☐
DOUBLE VISION	☐	☐	INCONTINENCE OF URINATION	☐	☐
CHANGE IN TASTE	☐	☐	PAIN DURING URINATION	☐	☐
SPEECH DIFFICULTIES	☐	☐	ERECTILE DYSFUNCTION	☐	☐
RINGING IN EARS	☐	☐	CURRENTLY PREGNANT	☐	☐
SINUS PAIN	☐	☐			

This clinic will only give controlled substances in certain instances and for acute reasons. It is our philosophy not to give Stadol, Fiorinal, Fioricet or other butalbital products for the treatment of headaches. If we decide to prescribe controlled substances (narcotics, sedatives, sleep aids, etc.) then no other controlled substances should be obtained from other physicians, unless we are notified . No controlled substances will be called in after hours. Controlled substance prescriptions that are lost, misplaced, etc. will not be refilled. _____*I agree.*

THANK YOU

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I made in the completion of this form. I understand that I may be seen by a Certified Registered Nurse Practitioner, who has been specially trained by the physician.

Signature: _____ Date: _____

NEUROLOGY AND NEURODIAGNOSTICS OF ALABAMA, LLC

PATIENT INFORMATION

Full Legal Name_____ **Name Normally Used (Nickname)**_____

Street Address (not PO Box)_____**City, State**_____ **Zip Code**_____

Mailing address (if different from above)_____

Home Phone (

Email _____)_____**Work Phone (**____)_____ ____ **Cell Phone (** **)**_____

Date of Birth____/____/____ **Age**_____ **Sex**_____ **Marital Status**_____

Social Security #____-____-____**Driver's License/State**_____ **Occupation**_____

Employer Name_____

Employer Address_____

Other Physicians you see_____

How did you hear about us?_____

SPOUSE'S INFORMATION

Name_____ **Date of Birth**_____

Address (If different from above)_____

Occupation_____ **Employer Name**_____

Employer Address_____

Home Phone (**)**_____ **Work Phone (** **)** _____ **Cell Phone (** **)**_____

INSURANCE INFORMATION

Responsible Party Name_____ **Phone # (** **)**_____**SSN**_____

Responsible Party Address_____

Primary Insurance_____ **Co-Pay $**_____

Contract #_____ **Group #**_____ **Effective Date**_____

Contract Holder's Name_____ **Relationship**_____ **Date of Birth**_____

Secondary Insurance_____ **Co-Pay $**_____

Contract #_____ **Group #** _____ **Effective Date**_____

Contract Holder's Name_____ **Relationship**_____ **Date of Birth**_____

Other Insurance Information_____

Emergency Contact_____ **Phone**_____ **Relation**_____

The Clinic and attending physician are authorized to furnish any medical records requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my care. My signature is also my authorization of assignment of benefits to the Clinic. I understand that I am directly responsible to Neurology and Neurodiagnostics of Alabama, LLC for all charges for medical and procedural services rendered to me, regardless of insurance coverage. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

Signature of Responsible Party_____**Date**_____

FINANCIAL POLICY

Neurology and Neurodiagnostics of AL
1000 Southlake Park, Suite 200
Hoover, AL 35244
205-536-8736

1. Payment for services rendered is expected at the time of treatment unless arrangements are made prior to treatment.

2. Our office will file insurance claims for services rendered, however, the patient is not relieved of responsibility for payment just because the patient has insurance.

3. Patients are responsible for updating all demographic information at every visit. If your insurance is a closed panel, requires a referral or is denied for any reason, you the patient, will be responsible for payment in full of the total visit. Patients are encouraged to call their insurance PRIOR to any visit to inquire if visits and procedures require a referral as well as whether or not they will be covered.

4. Patients must pay co-pays and deductibles due at the time services are rendered. Our office is contractually obligated to the insurance company to collect the patient's portion of the bill.

5. Balances due that are billed for 90 days will automatically be turned over to the collection agency, Amsher. There is a 50% up charge for all accounts that are turned over to collections.

6. Financial arrangements can be made for payment of bills.

7. For questions regarding billing, a billing manager can be reached at: 205-702-6602.

8. Copies of medical records are available for a fee. The fee charged follows the rules of the Alabama Board of Medical Examiners.

9. There is a $50 no-show fee for missed new patient and testing appointments. There is a $25 no-show fee for missed follow-up appointments. If you cannot keep your appointment, we ask that you cancel at least 24 hours in advance.

10. Those who no-show for new patient appointments or cancel more than twice, will not be able to make future appointments.

Signed:_____ Date:_____

NEUROLOGY AND NEURODIAGNOSTICS OF ALABAMA, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

1) I have received a copy of the Notice of Privacy Practices for Neurology and Neurodiagnostics of Alabama, LLC. Dr. Diane Counce reserves the right to modify the privacy practices outlined in this notice.

Name of Patient: _____

Signature of Patient: _____

Date: _____

Signature of Patient Representative: _____
(If patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient: _____

2) Please list below any persons with whom we can discuss your medical history and problems, i.e. family member, caregiver, etc. If there is no one you want to list, please state "none."

_____

_____

_____

3) Please list the method that you prefer us to use to contact you:

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

4) Do we have permission to leave a message with your lab and test results?

Yes_____ No_____

Signature: _____ **Date:** _____