

 **ColumbiaDoctors**  
**Adult New Patient Intake Form**

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Gender: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
Preferred Phone: Home or Mobile (circle one) Email: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact Phone: \_\_\_\_\_ Patient Marital Status: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Primary Care Provider (PCP): \_\_\_\_\_ PCP Phone: \_\_\_\_\_  
Referring Provider: \_\_\_\_\_ Referring Phone: \_\_\_\_\_  
Preferred Pharmacy: \_\_\_\_\_ Pharm Phone: \_\_\_\_\_  
Preferred Pharmacy Address: \_\_\_\_\_

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc...)

Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

**Ethnicity:**

- Decline Response
- Hispanic or Latino
- Not Hispanic or Latino

**Race:**

- Decline Response
- American-Indian or Alaska Native
- Asian

- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Other

Preferred Language: \_\_\_\_\_

- Decline Response

**Patient Financial Obligation Agreement**

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

**Notice of Privacy Practices: Acknowledgement of Receipt**

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

- Received
- N/A (only if you received the notice from ColumbiaDoctors previously)

**Information Disclosure and Consent**

ColumbiaDoctors will provide you with the health plans that your provider(s) accepts\*. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

***I read and agree to all of the above (Financial Agreement, Notice of Privacy, Insurance Information).***

Patient or Legal Guardian Name (Print): \_\_\_\_\_

Patient or Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

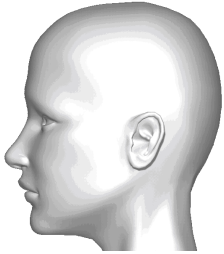
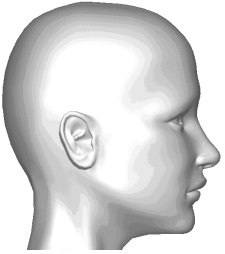
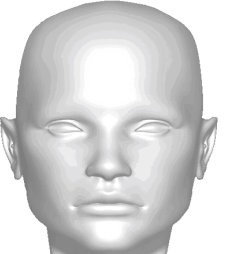

\*Please refer to our website: [columbiadoctors.org](http://columbiadoctors.org), for a list of insurances accepted by your provider.

# COLUMBIA UNIVERSITY HEADACHE CENTER: NEW PATIENT QUESTIONNAIRE

## HEADACHE CHARACTERISTICS Frequency and Severity

1. At what AGE did you get your <u>first</u> headache, of ANY kind?	
2. At what AGE did your headaches become problematic?	
3. On <u>AVERAGE</u> , how many DAYS per MONTH do you get headaches, of ANY KIND?	
4. On <u>AVERAGE</u> , how long do your typical headaches last? (MINUTES, HOURS, DAYS)	
5. On a scale of zero to ten, how would you rate your <u>WORST</u> pain?	<b>(please circle your answer)</b>
0      1      2      3      4      5      6      7      8      9      10 no pain                      mild                      moderate                      severe	
6. On a scale of zero to ten, how would you rate your <u>AVERAGE</u> pain?	<b>(please circle your answer)</b>
0      1      2      3      4      5      6      7      8      9      10 no pain                      mild                      moderate                      severe	
7. How many DAYS per MONTH do you get your <u>WORST</u> headaches?	
8. How long do your <u>WORST</u> headaches last? (MINUTES, HOURS, DAYS)	

### Location(s)

	Left 	Right 	Front 	Back 
1. Please indicate the regions affected:				
2. Is one side affected more than another?	Left side only Yes, _____% more on the left side	Right side only Yes, _____% more on the right side	No, both sides equally affected	No, alternates equally
3. What region(s) is/are affected?	<input type="checkbox"/> Front of the head <input type="checkbox"/> Back of the head <input type="checkbox"/> Side of the head <input type="checkbox"/> Top of the head	<input type="checkbox"/> Around the Eyes <input type="checkbox"/> Behind the Eyes <input type="checkbox"/> Shoulder <input type="checkbox"/> Neck	<input type="checkbox"/> Ear <input type="checkbox"/> Nose <input type="checkbox"/> Jaw <input type="checkbox"/> Other _____	

### Quality/Description of Pain

How would you describe your pain?	<b>Please (√)check ALL that apply:</b>
<input type="checkbox"/> Throbbing <input type="checkbox"/> Stabbing <input type="checkbox"/> Pounding <input type="checkbox"/> Pulsating <input type="checkbox"/> Tearing <input type="checkbox"/> Sharp <input type="checkbox"/> Pressure <input type="checkbox"/> Burning <input type="checkbox"/> Dull <input type="checkbox"/> Sudden <input type="checkbox"/> Gradual <input type="checkbox"/> Constant <input type="checkbox"/> Aching <input type="checkbox"/> Squeezing <input type="checkbox"/> Tightening <input type="checkbox"/> Other _____	

### Associated Features

When you have head pain, do you have any of the following?	<b>Please (√)check ALL that apply:</b>
<input type="checkbox"/> Sensitivity to light <input type="checkbox"/> Room spinning <input type="checkbox"/> Tearing of the eye ( right / left / both ) <input type="checkbox"/> Sensitivity to sound <input type="checkbox"/> Self spinning <input type="checkbox"/> Redness of the eye ( right / left / both ) <input type="checkbox"/> Sensitivity to smell <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Drooping of the eye ( right / left / both ) <input type="checkbox"/> Sensitivity to movement <input type="checkbox"/> Blurry vision <input type="checkbox"/> Nasal congestion ( right / left / both ) <input type="checkbox"/> Nausea <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Runny nose ( right / left / both ) <input type="checkbox"/> Vomiting <input type="checkbox"/> Facial flushing ( right / left / both ) <input type="checkbox"/> <input type="checkbox"/> Ear fullness ( right / left / both )	

Have you experienced any of the following?	Please (✓)check ALL that apply:
Head or neck trauma?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:
Loss of consciousness?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:
Infection/illness BEFORE the onset of your headache?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:
Toxic exposure BEFORE the onset of your headache?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:
Snoring or breathing pauses?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:
Jaw clicking, difficulty opening mouth, tooth grinding?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:
Use of tetracycline antibiotics, retinoic acid/vitamin A creams BEFORE the onset of your headache?	<input type="checkbox"/> No <input type="checkbox"/> Yes, describe:

Have you been diagnosed with any of the following?	Please (✓)check ALL that apply:
<input type="checkbox"/> Anxiety <input type="checkbox"/> Anorexia <input type="checkbox"/> Psychosis	<input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Bulimia <input type="checkbox"/> Obsessive Compulsive Disorder
	<input type="checkbox"/> Depression <input type="checkbox"/> Posttraumatic Stress <input type="checkbox"/> Other psychiatric disorder

#### DIAGNOSTIC STUDIES

Please provide dates and details of any studies, tests, or images that have been performed: (Attach copy of test results if possible)		
Study	Date	Findings
BRAIN MRI		
NECK (Cervical) MRI		
MRA/MRV		
Head CT		
Lumbar puncture		
Sleep Study		
EEG		
Other		

**PAST PREVENTIVE MEDICATIONS**

Medication Generic Name ( <i>Brand Name</i> )	What was the highest dose (mg)?	How many times per day?	When/how long was this used?	Did this change the intensity, duration or frequency of the headache? (If so, how?)	Were there any side effects? (If so, what were they?)
Amitriptyline ( <i>Elavil</i> )					
Nortriptyline ( <i>Pamelor</i> )					
Doxepin ( <i>Sinequan</i> )					
Imipramine ( <i>Tofranil</i> )					
Cyproheptadine ( <i>Periactin</i> )					
Venlafaxine ( <i>Effexor</i> )					
Duloxetine ( <i>Cymbalta</i> )					
Escitalopram ( <i>Lexapro</i> )					
Topiramate ( <i>Topamax</i> )					
Zonisamide ( <i>Zonegran</i> )					
Valproate ( <i>Depakote</i> )					
Gabapentin ( <i>Neurontin</i> )					
Lamotrigine ( <i>Lamictal</i> )					
Carbamazepine ( <i>Tegretol</i> )					
Oxcarbazepine ( <i>Trileptal</i> )					
Acetazolamide ( <i>Diamox</i> )					
Propranolol ( <i>Inderal</i> )					
Nadolol ( <i>Corgard</i> )					
Atenolol ( <i>Tenormin</i> )					
Metoprolol ( <i>Toprol</i> )					
Candesartan ( <i>Atacand</i> )					
Flunarizine ( <i>Sibelium</i> )					
Verapamil ( <i>Calan, Veralan</i> )					
Indomethacin ( <i>Indocin</i> )					
Lithium ( <i>Eskalith, Lithobid</i> )					
Methysergide ( <i>Sansert</i> )					
Vitamin B2 ( <i>Riboflavin</i> )					
Magnesium					
Butterbur ( <i>Petadolex</i> )					
Feverfew					
Melatonin					

**PAST ACUTE MEDICATIONS**

Medication	Dose (mg)	Route of administration (oral, nasal, injection)	Did this change the intensity or duration of the headache? (If so, how?)	Were there any side effects? (If so, what were they?)
Sumatriptan ( <i>Imitrex</i> )				
Treximet				
Rizatriptan ( <i>Maxalt</i> )				
Zolmitriptan ( <i>Zomig</i> )				
Naratriptan ( <i>Amerge</i> )				
Eletriptan ( <i>Relpax</i> )				
Almotriptan ( <i>Axert</i> )				
Frovatriptan ( <i>Frova</i> )				
Ergotamine tablets ( <i>Cafergot, Ergomar, Migergot, Migracet, Wigraine</i> )				
Ergotamine suppository ( <i>Cafergot</i> )				
Dihydroergotamine nasal spray ( <i>Migranal</i> )				
Promethazine ( <i>Phenergan</i> )				
Chlorpromazine ( <i>Thorazine</i> )				
Prochlorperazine ( <i>Compazine</i> )				
Metoclopramide ( <i>Reglan</i> )				
Naproxen ( <i>Naprosyn, Aleve</i> )				
Ibuprofen ( <i>Advil, Motrin</i> )				
Acetaminophen/Aspirin/Caffeine ( <i>Excedrin</i> )				
Nabumetone ( <i>Relafen</i> )				
Flurbiprofen ( <i>Ansaid</i> )				
Mefenamic Acid ( <i>Ponstel</i> )				
Ketorolac ( <i>Toradol</i> )				
Diclofenac ( <i>Cambia, Voltaren</i> )				
Steroids (e.g., <i>Medrol, prednisone</i> )				
Muscle relaxants (e.g., <i>tizanidine, methocarbamol</i> )				
Butalbital-containing compounds ( <i>Fioricet, Fiorinal</i> )				

**IN THE PAST, WHAT OTHER MEDICATIONS FOR HEADACHE HAVE YOU USED? (Attach additional sheets if needed)**

Medication	What was the highest dose (mg)?	How many times per day?	When/how long was this used?	Did this change the intensity, duration or frequency of the headache? (If so, how?)	Were there any side effects? (If so, what were they?)

**INTRAVENOUS THERAPIES, HOSPITALIZATIONS, and PROCEDURES FOR HEADACHE**

Treatment	Date	Description of Treatment and Effect
Intravenous DHE (dihydroergotamine)		
Intravenous valproic acid ( <i>Depakote</i> )		
Intravenous lidocaine		
Greater occipital nerve block		
Botox Injections		
Implanted stimulator device		
Surgical intervention		
Other:		

**ADJUNCTIVE THERAPIES**

Type of Treatment	Date	Effect
Cefaly (supraorbital nerve stimulator)		
Transcranial Magnetic Stimulation (TMS)		
Oxygen therapy		
Acupuncture		
Biofeedback		
TENS therapy		
Chiropractic Manipulation		
Massage Therapy		
Physiotherapy		
Homeopathy		
Other:		

## MIDAS (Migraine Disability Assessment)

### About MIDAS:

The MIDAS (migraine disability assessment) questionnaire is a tool to help you measure the impact your headaches have on your life over the last 3 months. The best way to this is by counting the numbers of days of your life which are affected by Headaches. You can do this for yourself as follows:

### INSTRUCTIONS:

- Please complete Questions about ALL your headaches you have had over the last 3 months.
- Write your answer in the box next to each question.
- If a single headache affects more than one area of your life (e.g., work and family life) it is counted more than once.
- Mark question as zero if you did not do the activity in the last three months.
- For questions 1 and 2, **work or school** means paid work or education if you are a student at school or college.
- For Questions 3 and 4, **household work** means activities such as housework, home repairs and maintenance, shopping as well as caring for children and relatives.

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
<b>To score, add points for answers in each column</b>	<b>Total:</b> days

MIDAS Score	MIDAS Grade	Definition	Recommendations
0–5	I	Minimal or infrequent disability	MIDAS Grade I usually indicates low medical need. Simple, over-the-counter analgesics may be effective in the acute treatment of these patients. However, the impact of even a few lost days on the lifestyle of these patients should be assessed. Also, some patients with a MIDAS Grade I, such as those with infrequent, but severe migraine, may benefit from first-line treatment with specific migraine therapies (e.g. triptans). MIDAS Grade I patients who have failed to achieve effective relief with simple analgesics should also be considered for triptan therapy.
6–10	II	Mild or infrequent disability	MIDAS Grade II usually indicates moderate medical need. The patients may require an acute prescription medication. Some MIDAS Grade II patients may also qualify for first-line triptan medication if their headaches are severe. For example, a score of 10 could mean that a patient is missing ten days of school or paid work, so the headaches could be causing severe disruption in their lives. MIDAS Grade II patients should also qualify for first-line triptan medication if they have failed on simple analgesics.
11–20	III	Moderate disability	MIDAS Grade III/IV indicates a high medical need. These patients are experiencing significant disability and their migraine attacks are having a severe impact on their lives. Specific acute therapy, such as a triptan, is usually the most appropriate therapy for these patients, providing they are suitable recipients. Prophylactic treatment should also be considered. Please note that a very high MIDAS score could also indicate a high frequency of non-migraine headache, and these patients should be managed accordingly.
≥21	IV	Severe disability	

Patient's Signature \_\_\_\_\_

Reviewed with the patient on \_\_\_\_\_

Physician's Signature \_\_\_\_\_