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, for a list of insurances accepted by your provider.**

Name: _____

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?	**(please circle your answer)**

0 1 2 3 4 5 6 7 8 9 10
no pain mild moderate severe

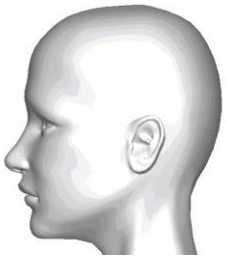
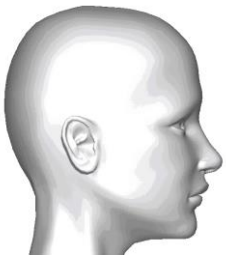
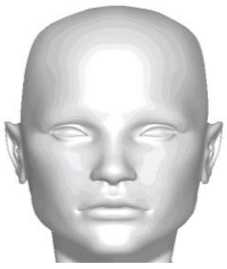
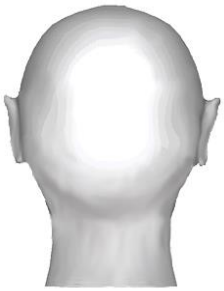
6. On a scale of zero to ten, how would you rate your <u>AVERAGE</u> pain?	**(please circle your answer)**

Text

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?	☐ Front of the head	☐ Around the Eyes	☐ Ear
	☐ Back of the head	☐ Behind the Eyes	☐ Nose
	☐ Side of the head	☐ Shoulder	☐ Jaw
	☐ Top of the head	☐ Neck	☐ Other_____

Quality/Description of Pain

How would you describe your pain?	Please (√)check ALL that apply:		
☐ Throbbing	☐ Stabbing	☐ Pounding	☐ Pulsating
☐ Tearing	☐ Sharp	☐ Pressure	☐ Burning
☐ Dull	☐ Sudden	☐ Gradual	☐ Constant
☐ Aching	☐ Squeezing	☐ Tightening	☐Other_____

Associated Features

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

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

Have you been diagnosed with any of the following?	**Please (√)check ALL that apply**:		
☐ Anxiety	☐ Bipolar Disorder	☐ Depression	☐ Other psychiatric disorder
☐ Anorexia	☐ Bulimia	☐ Posttraumatic Stress	
☐ Psychosis	☐ Obsessive Compulsive 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 (*Brand Name*)	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 (*Elavil*)					
Nortriptyline (*Pamelor*)					
Doxepin (*Sinequan*)					
Imipramine *(Tofranil)*					
Cyproheptadine *(Periactin)*					
Venlafaxine *(Effexor)*					
Duloxetine *(Cymbalta)*					
Escitalopram *(Lexapro)*					
Topiramate (*Topamax*)					
Zonisamide *(Zonegran)*					
Valproate (*Depakote*)					
Gabapentin (*Neurontin*)					
Lamotrigine *(Lamictal)*					
Carbamazepine *(Tegretol*)					
Oxcarbazepine *(Trileptal)*					
Acetazolamide (*Diamox*)					
Propranolol (*Inderal*)					
Nadolol *(Corgard)*					
Atenolol *(Tenormin*)					
Metoprolol (*Toprol*)					
Candesartan (*Atacand*)					
Flunarizine (*Sibelium*)					
Verapamil (*Calan, Veralan*)					
Indomethacin (*Indocin*)					
Lithium (*Eskalith, Lithobid)*)					
Methysergide *(Sansert)*					
Erenumab (Aimovig)					
Fremanezumab (Ajovy)					
Galcanezumab (Emgality)					
Vitamin B2 (Riboflavin)					
Magnesium					
Butterbur (Petadolex)					
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 (*Imitrex*)				
Treximet				
Rizatriptan (*Maxalt*)				
Zolmitriptan (*Zomig*)				
Naratriptan (*Amerge*)				
Eletriptan (*Relpax*)				
Almotriptan (*Axert*)				
Frovatriptan (*Frova*)				
Ergotamine tablets (*Cafergot, Ergomar, Migergot, Migracet, Wigraine*)				
Ergotamine suppository (*Cafergot*)				
Dihydroergotamine nasal spray (*Migranal*)				
Promethazine (*Phenergan*)				
Chlorpromazine (*Thorazine*)				
Prochlorperazine (*Compazine*)				
Metoclopramide (*Reglan*)				
Naproxen (*Naprosyn, Aleve*)				
Ibuprofen *(Advil, Motrin*)				
Acetaminophen/Aspirin/Caffeine *(Excedrin)*				
Nabumetone (*Relafen*)				
Flurbiprofen (*Ansaid*)				
Mefenamic Acid (*Ponstel*)				
Ketorolac (*Toradol*)				
Diclofenac (*Cambia, Voltaren*)				
Steroids *(e.g., Medrol, prednisone)*				
Muscle relaxants *(e.g., tizanidine, methocarbamol)*				
Butalbital-containing compounds *(Fioricet, Fiorinal)*				

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 *(Depakote)*		
Intravenous lidocaine		
Greater occipital nerve block		
Botox Injections		
Implanted stimulator device		
Surgical intervention		
Sphenopalatine nerve block		
Other:		

ADJUNCTIVE THERAPIES

Type of Treatment	Date	Effect
Cefaly (supraorbital nerve stimulator)		
Transcranial Magnetic Stimulation (TMS)		
Vagus Nerve Stimulaiton (VNS)		
Oxygen therapy		
Acupuncture		
Biofeedback		
TENS therapy		
Chiropractic Manipulation		
Massage Therapy		
Physiotherapy		
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
To score, add points for answers in each column	**Total:**	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 _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total score from columns 1 - 4 =

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Patient Health Questionnaire-2 (PHQ-2)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total score from columns 1 - 4 =

Source: Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. Medical Care. 2003;41:1284-92.

Patient's Signature _____

Reviewed with the patient on _____

Physician's Signature _____