Vertrees
Headache Center

PATIENT DEMOGRAPHICS:

Legal Name: _____

Date of Birth: _____ Gender: _____

Street Address: _____

City: _____ State: ____ Zip Code: _____

Best Contact Number: _____ Cell Number: _____

Best Email Address: _____

Preferred Pharmacy Name & Address/Cross Streets:

_____

_____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Primary Care Provider Name: _____

Did anyone refer you to VHC? _____

INSURANCE INFORMATION:

Primary Plan Name: _____

Member ID: _____

Group ID: _____

Provider Contact Number: _____

Who is the Primary Insured? _____

Relationship: _____ Date of Birth: _____

Prescription Drug Program:_____

Rx BIN: _____

Rx PCN: _____

Patient Name: _____

Your Headache History

Please fill out to the best of your ability.
A thoroughly answered form helps our visits go more efficiently.

Have you had any of the following occur recently for the first time?
❑Fever ❑Weight loss ❑Fatigue ❑Confusion ❑Pregnancy
❑Neck stiffness ❑Pain when moving neck ❑Speech change
❑One-sided weakness ❑Pulsing/Whooshing in the ear ❑Visual changes ❑Eye pain
❑Difficulty swallowing ❑Dizziness ❑Passing out ❑Other: _____

Has your headache's behavior changed dramatically recently?
❑Headaches are a new problem for me ❑I have a new kind of headache
❑I don't have a headache but have a new symptom that might be a migraine
❑More frequent headaches ❑Headache in a new location
❑More severe headache ❑Headache that is sudden and severe
❑Headache worse with change in position ❑Headache worse with exercise
❑Headache worse with coughing/straining ❑Headaches worse with sex
Please Explain_____

Do you have a history of any of the following?
❑Autoimmune/rheumatologic disease ❑Cancer ❑HIV ❑Immunosuppression
❑Thyroid disease ❑High blood pressure ❑Head injury ❑Other
Please explain: _____

TIMING/DURATION:

1. How many days this past month did you have any headache or related symptoms?____/30
2. How many days this past month were you completely symptom free?_____/30
3. How long has your current frequency/pattern been going on? _____
4. How old were you when you had your very first headache (any type)? _____
5. How long does a headache last if you **DON'T** treat it? _____
6. What is the longest a headache has ever lasted? _____
7. On an average day how long does your headache last?_____

Do you have more than one kind of headache? YES/NO. If Yes, please explain:
1._____
2._____
3._____

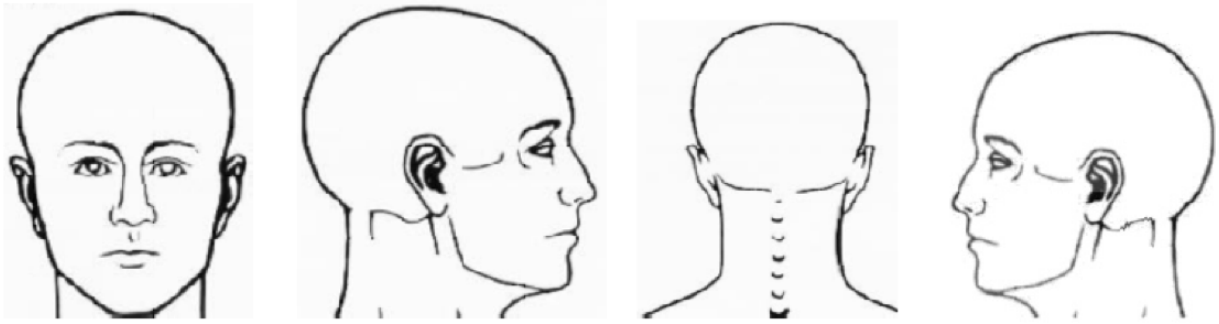
Patient Name: _____

WHAT KIND OF DISCOMFORT DO YOU EXPERIENCE?

❑Pressure ❑Squeezing ❑Vice grip ❑Throbbing, Pounding, or Pulsing ❑Stabbing
❑Burning ❑Electrical ❑Shooting ❑Sharp ❑Aching ❑Dull
❑No discomfort ❑Other: _____

HEADACHE LOCATION: Draw location of typical pain on figures below.

Use circles, dots, or even arrows to show movement, spread, or progression.



❑Right ❑Left ❑Both at the same time ❑Changes sides/migrates
❑More than one kind of headache

SYMPTOMS ASSOCIATED WITH A TYPICAL HEADACHE OR SPELL:

They may occur before, during or after a headache, every time, sometimes, or rarely.

❑Sensitivity to light ❑Sensitivity to noise ❑Sensitivity to smells ❑Nausea ❑Vomiting
❑Neck/shoulder pain, stiffness, or tenderness ❑Skin is sensitive to the touch
❑Sinus pressure/congestion

❑Blurry vision ❑Blind spots ❑Zig-zag lines ❑Double vision ❑Total blindness
❑Flashing lights/colored lights ❑Tunnel vision

❑Dizziness ❑Lightheadedness ❑Difficulty finding words ❑Slurred speech
❑Ringing in ears
❑Weakness (where) _____❑Numb/tingling (where) _____
❑Loss of appetite ❑Stomach pain ❑Other abdominal symptoms

❑Memory issues ❑Difficulty concentrating ❑Moody ❑Anxiety ❑ Depression
❑Euphoria

❑Droopy eyelid on side of pain ❑Eye-tearing on side of pain ❑Eye-redness on side of pain ❑Nose stuffy on side of pain ❑Nose runny on side of pain
❑Fatigue ❑Yawning ❑Sweating ❑Thirst ❑Food craving/hunger ❑Urination

Patient Name: _____

Patient Name: _____

PSYCHOLOGICAL HISTORY:

❑Anxiety ❑Depression ❑Bipolar ❑PTSD

❑Other_____

❑Physical abuse ❑Emotional abuse ❑Sexual abuse Is this current? Y/N

Everyone has stress. What are your source(s) of stress? _____

_____

LIFESTYLE:

Occupation: _____

Marital Status: _____ # of Children/Ages: _____

Military service (current or former): _____ ❑History of blast/shock wave exposure

Do you exercise regularly? Yes/No Type of activity: _____

Days a week of exercise _____

Are you on a special diet (describe briefly)? _____

Are you overweight or obese? **Yes/No** Current Height/Weight:_____

SLEEP HISTORY: Poor sleep is a significant perpetuating factor for headaches. A recent study found that 98 out of 100 patients had a sleep problem that impacted their headaches. **Please tell us about your sleep**.

Hours of sleep per night: _____

Do you have problems with:

❑Falling asleep

❑Waking up in the middle of the night? If so, how many times on average? _____

❑Getting up to urinate? How many times? _____

❑Snoring. If yes, have you had a sleep study? _____Do you have sleep apnea?

Yes/No If so, is your sleep apnea treated? **YES/NO** With What? _____

❑Grinding or clenching teeth

❑Jaw pain

❑Waking up with headaches

❑Having headaches that wake you up in the middle of the night

❑Night shift or irregular work schedule

❑Wake up feeling that you have not gotten enough sleep?

❑Strong urge to move legs at night/in bed (creepy-crawly, aches)?

❑Other problems with your sleep? Tell us about it: _____

❑Number alcoholic beverages per week:

_____

Patient Name: _____

❑ Number of caffeinated drinks per day (8 oz servings):
_____

❑ What is the latest time of your caffeine intake daily ___:___ am pm

Patient Name: _____

TRIGGERS: Do any of the following tend to BRING ON your headaches?

1. Alcohol:
   ❑Beer, ❑Wine (tyramine) ❑Any alcohol
2. Foods:
   ❑Sausages/cold cuts (nitrates/nitrites) ❑Aged cheese ❑Aspartame (artificial sweetener) ❑Caffeine ❑ Avocado ❑Bananas ❑Some beans ❑Chocolate ❑Citrus fruits ❑Onions ❑Peanut butter ❑Peas ❑Pork ❑Sour cream ❑Vinegar ❑Yogurt ❑Monosodium glutamate (MSG)
3. Lifestyle:
   ❑Stress ❑Anxiety ❑Dehydration ❑Skipping meals ❑Varied meal times ❑Too much sleep ❑Too little sleep ❑Varied sleep schedule ❑Job ❑Housework ❑ Family ❑ Legal ❑School ❑ Relationships ❑Social life ❑Legal issues
4. Environmental:
   ❑Sunlight ❑Weather changes ❑Strong odors ❑ Certain lighting
5. Physical:
   ❑Menstrual cycle ❑Menopause ❑Birth control/hormone replacement ❑Pregnancy ❑Coughing ❑Sneezing ❑Laughing ❑Bending ❑Lifting ❑Straining or bearing down ❑Sexual activity ❑Lying down ❑Sitting ❑Standing
6. Other Triggers:_____

Have you been diagnosed with:	In the past	Currently have it
Fibromyalgia		
Irritable bowel syndrome		
Pelvic Pain		
TMJ		
Painful bladder syndrome		

Are your headaches better at any time of day? _____
Are your headaches worse at any time of day? _____

Do you have family members with headaches? Who? _____
_____

Patient Name: _____

PRIOR INTERVENTIONS:
(**CHECK if tried and unhelpful, CIRCLE if helpful**)**:**

❑Nerve blocks ❑Trigger point injections ❑Trigger point dry needling ❑Botox
❑Physical therapy ❑Chiropractic ❑Massage ❑Acupuncture ❑Migraine diet
❑Relaxation ❑Biofeedback ❑Psychologist/counselor ❑Meditation
❑Cefaly ❑GammaCore ❑SPG blocks

CURRENT HEADACHE MEDICATIONS:
Please list the medications you currently take for HEADACHES. Continue on the back if needed.

Medication	**Helpful?**	**Side Effects?**	**Number of days per week taken**
	Yes/No/Somewhat	No/Tolerable/Intolerable	2 or less/more than 2
	Yes/No/Somewhat	No/Tolerable/Intolerable	2 or less/greater than 2
	Yes/No/Somewhat	No/Tolerable/Intolerable	2 or less/greater than 2
	Yes/No/Somewhat	No/Tolerable/Intolerable	2 or less/greater than 2
	Yes/No/Somewhat	No/Tolerable/Intolerable	2 or less/greater than 2

Please list medications you take for OTHER REASONS (prescriptions, supplements, or over the counter, as-needed medications)? Continue on the back if needed.

_____
_____
_____
_____
_____
_____
_____
_____

Patient Name: _____

PREVIOUS HEADACHE MEDICATIONS:

Preventive Medications	**Have you tried this medication?**	**Helpful?**	**Side Effects?**	**How Long Taken? When?**
Valproic acid (Depakote)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Topiramate (Topamax, Trokendi, Qudexy)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Gabapentin (Neurontin)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Pregabalin (Lyrica)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Zonisamide (Zonegran)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Lamotrigine (Lamictal)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Other Anti-seizure Medication(s):	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Amitriptyline (Elavil)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Nortriptyline (Pamelor)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Doxepin (Sinequan)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Protriptyline (Vivactil)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Imipramine (Trofanil)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	

Patient Name: _____

Fluoxetine (Prozac)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Paroxetine (Paxil)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Sertraline (Zoloft)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Citalopram (Celexa)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Escitalopram (Lexapro)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Venlafaxine (Effexor)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Duloxetine (Cymbalta)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Other antidepressant medication(s):	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Metoprolol (Toprol, Lopressor)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Atenolol (Tenormin)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Propranolol (Inderal)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Carvedilol (Coreg)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Nadolol (Corgard)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Verapamil (Isoptin, Calan)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	

Patient Name: _____

Amlodipine (Norvasc)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Diltiazem (Cardizem)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Nifedipine (Procardia)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Candesartan (Atacand)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Losartan (Cozaar)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Other antihypertensive medication(s):	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Memantine (Namenda)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Aimovig (erenumab)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Ajovy (fremanezumab)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Vyepti (eptinezumab)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Emgality (galcanezumab)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	
Nurtec (rimegepant)	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	

Patient Name: _____

Other Headache Preventatives not previously mentioned:	Yes/No/Not Sure	Yes/No/Somewhat	No/Tolerable /Intolerable	

Acute Treatment Medications	**Have you tried this medication**	**Helpful?**	**Side effects?**	**Number of days per week taken**
Sumatriptan (Imitrex, Sumavel, Zembrace, etc)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Treximet (sumatriptan/naproxen)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Zolmitriptan (Zomig)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Rizatriptan (Maxalt)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Naratriptan (Amerge)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Almotriptan (Axert)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Relpax (eletriptan)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Frova (frovatriptan)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Ubrelvy (ubrogepant)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Nurtec (rimegepant)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Reyvow (lamsitidan)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	

Patient Name: _____

Migranal (DHE nasal)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
DHE injections	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Other ergotamines/ergot derivatives	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Prednisone	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Indomethacin (Indocin)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Naproxen (Naprosyn, Aleve, Anaprox)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Ibuprofen (Advil, Motrin)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Diclofenac (Cambia/Zipsor/Voltaren/)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Meloxicam (Mobic)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Celecoxib (Celebrex)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Aspirin	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Other NSAIDs	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Isometheptine compounds (Midrin/Duradrin/Prodrin)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Butalbital compounds (Fiorinal, Fioricet)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Goody's Powder/BC Powder	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Excedrin products	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Tylenol products	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	

Patient Name: _____

Tizanidine (Zanaflex)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Cyclobenzaprine (Flexeril)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Carisoprodol (Soma)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Baclofen (Lioresal)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Methocarbamol (Robaxin)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Metaxalone (Skelaxin)	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	
Other as-needed medications for headache not previously mentioned:	Yes/No/Not Sure	Y/N/Somewhat	Yes/No	

Opioid/Opiate Medications	**Have you tried this medication?**	**Current Medication?**	**Number of days per week taken**
Hydrocodone (Norco etc.)	Yes/No/Not sure	Yes/No	
Tramadol (Ultram, etc.)	Yes/No/Not sure	Yes/No	
Talwin NX (pentazocine/naloxone)	Yes/No/Not sure	Yes/No	
Tylenol with codeine	Yes/No/Not sure	Yes/No	
Hydromorphone (Dilaudid)	Yes/No/Not sure	Yes/No	
Morphine (MS Contin)	Yes/No/Not sure	Yes/No	
Oxycontin or oxycodone	Yes/No/Not sure	Yes/No	
Methadone (Methadose)	Yes/No/Not sure	Yes/No	

Patient Name: _____

Oxymorphone (Opana, Opana ER)	Yes/No/Not sure	Yes/No	
Buprenorphine (Butrans, Subutex, etc.)	Yes/No/Not sure	Yes/No	
Stadol (butorphanol)	Yes/No/Not sure	Yes/No	
Nubain (nalbuphine)	Yes/No/Not sure	Yes/No	
Fentanyl (Duragesic, Actiq Fentora etc.)	Yes/No/Not sure	Yes/No	
Tapentadol (Nucynta)	Yes/No/Not sure	Yes/No	
Other:	Yes/No/Not sure	Yes/No	

TREATMENT PREFERENCES:

1. Are you okay with taking pharmaceutical medications? Y/N
2. Do you prefer natural remedies/lifestyle modifications? Y/N
3. Do you have any other preferences regarding your treatment strategies?_____
4. Do you have any goals for treatment (ie fewer headaches, less disability, spending more time with family, etc)?_____
   _____
   _____

WRAPPING UP:

Are there any other factors contributing to your headaches, or is there anything else we need to know that was not covered in this survey?

_____
_____
_____
_____
_____
_____
_____

Patient Name: _____

QUESTIONNAIRES: Bear with us! These questionnaires help us determine if there are other factors contributing to your headaches.

Allodynia Questionnaire

Question: How often do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you engage each of the following?	**Does not apply**	**Never**	**Rarely**	**Less than half the time**	**More than half the time**
Combing your hair					
Pulling your hair back					
Shaving your face					
Wearing eyeglasses					
Wearing contact lenses					
Wearing earrings					
Wearing a necklace					
Wearing tight clothing					
Taking a shower (when the water hits your face)					
Resting your face or head on a pillow					
Exposure to heat (cooking, washing your face with warm water)					
Exposure to cold (cold pack, washing your face with cold water)					

Patient Name: _____

MIDAS:

Please fill out a number of days after each question. DO NOT provide a range of days. Think only about the past 90 days, not an average.

	# days
1. On how many days in the past 3 months did you miss work or school because of your headaches (if you didn't attend work or school enter zero)	
2. How many days in the last 3 months was productivity at work or school reduced by half or more because of your headaches (do not include the days you counted in question 1 where you missed work or school. If you didn't attend work or school enter zero)	
3. On how many days in the last 3 months did you not do household work because of your headaches? (If you don't normally do household work, enter zero)	
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 the days you counted in question 3, where you did not do household work. If you don't normally do household work, enter zero)	
5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?	
TOTAL (Questions 1-5 only)	
A. On how many days in the last 3 months did you have a headache? (If headache lasted more than one day, count each day)	
B. On a scale of 0-10, on average, how painful were these headaches? (where 0=no pain at all, 10=pain which is as bad as it can be)	

Patient Name: _____

STOP-BANG Sleep Apnea Risk

		Yes	No
S	**Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?**		
T	**Do you often feel tired, fatigued, or sleepy during the daytime?**		
O	**Has anyone ever observed you stop breathing during sleep?**		
P	**Do you have or are you being treated for high blood pressure?**		
B	**Is your body mass index greater than 35 kg/m2?**		
A	**Are you older than 50 years?**		
N	**Does your neck measure more than 15 ¾ inches (40cm) around?**		
G	**Is your gender male?**		
	TOTAL # Yes		

Patient Name: _____

GAD-7:

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not sure**	**Several days**	**Over half the days**	**Nearly every day**
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				
	Not difficult	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
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 people?				

Patient Name: _____

PHQ-9:

Over the last 2 weeks, how often have you been bothered by 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 TV				
Moving or speaking so slowly that other people could have noticed. Or the opposite - bing 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				
	Not difficult	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				

Patient Name: _____

PCL-C:

Note: If you have NEVER had a major stressful experience in the past, leave blank.

If you had a major stressful event, what was it? _____

When did it occur? _____

		Not at all	A little bit	Moderately	Quite a bit	Extremely
B	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?					
	Repeated, disturbing dreams of a stressful experience from the past?					
	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?					
	Feeling very upset when something reminded you of a stressful experience of the past?					
	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?					
C	Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it?					
	Avoiding activities or situations because they reminded you of a stressful experience from the past?					
	Trouble remembering important parts of a stressful experience from the past?					
	Loss of interest in activities that you used to enjoy?					
	Feeling distant or cut off from other people?					
	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
	Feeling as if your future somehow will be cut short?					
D	Trouble falling or staying asleep?					
	Feeling irritable or having angry outbursts ?					
	Having difficulty concentrating?					
	Being “superalert” or watchful or on guard?					
	Feeling jumpy or easily startled?					

Patient Name: _____

Your Medical History

Please fill out to the best of your ability.
A thoroughly answered form helps our visits go more efficiently.

Please list all of your other current or past medical issues and surgeries:

_____
_____
_____
_____
_____

Do any significant medical issues run in your family? Please list:

_____
_____
_____
_____
_____

Drug Allergies:

_____
_____

Environmental Allergies:

Have you had allergy testing? **YES/NO** If yes, by whom? _____
If Yes, please list your allergens, if any:

_____
_____
_____
_____
_____

Substance History:

Do you smoke or consume other tobacco products?
If so, how many packs per day? _____ For how long? _____

Do you drink alcoholic beverages? _____ How many per week? _____

Patient Name: _____

Review of Systems:

Have you had any of the following symptoms in the past 2-4 weeks? **PLEASE CIRCLE THE ONES THAT APPLY**.

Constitutional: fever, chills, unexplained weight loss, loss of appetite
ENT: Problems hearing, runny nose, ringing in ears, sore throat
CV: heart palpitations, chest pains, swelling of legs
Resp: shortness of breath, wheezing, cough, coughing up phlegm or blood
GI: abdominal pain, diarrhea, constipation, bloody or black stools, nausea, vomiting
GU: Painful urination, urgency, prostate or bladder problems, impotence
MS: Joint pain, muscle pain, neck or back pain, swelling of joints, joint deformities
Skin: Persistent rash, itching, new skin lesion, change in skin lesion, hair loss
Endo: Heat or cold intolerance, menstrual changes, frequent hunger/urination/thirst
Heme: Easy bleeding/bruising, anemia, leukemia, swollen glands/lymph nodes.
Allergic/Immunologic: Seasonal allergies, hay fever, itching, frequent infections
Psych: Insomnia, irritability, depression, anxiety, hallucinations, compulsions
Neuro: vision change or loss, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions

Patient Name: _____

Patient Agreement

Cancellation and Late Policies

There is no charge for appointments canceled 24 or more hours before the start of your scheduled appointment. Patients arriving late will only be seen during their regularly scheduled appointment time and may have their appointment times cut short. If you arrive too late you may be asked to reschedule. Late patients are charged the full fee for their scheduled service.

No Show

Patients who do not show for their scheduled appointment will be charged the full amount of the visit unless they cancel 24 hours or more in advance.

Behavior

A functional physician-patient relationship relies on mutual trust and respect between the respective parties. We understand that when people don't feel their best, they don't always act their best, and we believe in second chances in most cases. However, behaviors including but not limited to rudeness, foul language, insults, obstinacy, treatment noncompliance, drug seeking, or lying may be grounds for dismissal from our clinic, at the discretion of our medical director.

Disclosure of Fees

Obtaining prior authorizations for special medications can take hours of time. Our fee helps us support our administrative staff. The standard fee for prior authorizations is $50.00 for each medication charged once a year.

The clinic charges $50.00 for completing FMLA, accommodation letters, and disability forms. We should know you well before we are entrusted to fill out this kind of paperwork. Therefore, it is at the discretion of the doctor. Functional assessments cannot be performed in our office due to a lack of necessary equipment, but we are happy to provide you with any medical records to support your disability claims.

I have read and acknowledged receipt of the above disclosures.

Patient Signature: _____ Date: _____

Patient Name: _____

Now partnering with SiteRx!

As a part of our commitment to providing you with as many care options as possible we are offering access to clinical trials. SiteRx will be helping us match our patients with studies.

As new studies become available that we think you might be a good candidate for, we will refer you to our partners at SiteRx. SiteRx will contact you to share all the information regarding what the study entails at which point you can decide whether or not you are interested in participating and pursue next steps to enroll if you so wish.

What is a clinical trial?

A type of research that studies the effects of a medication on humans that includes its effects on the body, it's benefits, as well as side effects. Most medications that are used to treat conditions and disease have been tested in clinical trials. Every study contains a group of volunteers who do not receive the active medication which is called the placebo. This way, the researchers can analyze if the study drug is effective enough in order to prescribe.

Benefits of a clinical trial

- The opportunity to receive a new treatment before it is available to the general public and at no cost to you.
- You are helping find a better treatment, or novel treatment, for the specific disease or condition.
- You play an active role in your health care.
- During your participation in the trial, you will receive additional oversight and testing in addition to the care of your Primary Care Provider and Specialists.
- Some clinical trial testing includes diagnostics that are not available to the public or not covered by insurance companies.

_____ Yes, I am interested in learning more about Site Rx.

_____ No, I am not interested in learning more about Site Rx.