Account #_________________

PATIENT REGISTRATION

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

Date____________________________ ☐**New** ☐**Update**

Name____ Date of Birth ________________ ☐ Male
Last First Middle ☐ Female

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 #__________________________ **Subscriber's** 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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Account #________________

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______________________________	__________	________________________________
Patient Signature	**Date**	**Designated Power Of Attorney**

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______________________	____________________________	______________________
Patient Signature	**Date**	**Designated Power Of Attorney**

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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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Account #________________

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

Current height ______________ Current weight ______________

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Account #________________

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 Imaging (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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Account #________________

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?

THE NEUROLOGY CENTER OF SOUTHERN CALIFORNIA

Account #________________

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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Account #________________

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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Account #________________

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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Patient Name: ______________________________________

HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

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

____

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Account #________________

Sleep Survey

Name: ___________________________ **DOB:** _____________

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

THE NEUROLOGY CENTER OF SOUTHERN CALIFORNIA

Account #_______________

Pain Survey

Name: _________________________ DOB: ___________

Do you have chronic pain and/or are you interested in seeing our interventional spine and pain specialist to learn about non-opioid medication treatments?

Yes____ No ____

__________________________ **Was a pain consult ordered? Yes ___ No ___**

Physician Signature

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