MS SC

MIGRAINE SURGERY SPECIALTY CENTER

WWW.HEADACHESURGERY.COM | 805.969.9004 | SANTA BARBARA, CA | DENVER, CO

HEADACHE HISTORY FORM

IF THIS IS YOUR FIRST VISIT, PLEASE TAKE THE TIME TO FILL THIS FORM OUT COMPLETELY.

Patient Name: _____Age:_____Date of Birth: _____Weight: _____Height:_____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

E-mail address _____ Emergency Contact _____

Emergency Contact Info _____

Emergency Contact relationship to you _____

Social Security#: _____Occupation: _____

How did you hear about us? _____

Reason for today's visit: _____

_____

Primary Care Physician: _____ Phone: _____ Fax _____

Address _____ City/State _____ Zip _____

Referring Physician: _____ Phone: _____Fax _____

Address _____City/State _____ Zip _____

_____

Primary Insurance: _____ Phone #: _____

Address: _____Policy #: _____Group #: _____

Policy Holder: _____ Social Security #: _____DOB: _____

Secondary Insurance: _____Phone #: _____

Address: _____Policy #: _____Group #: _____

Policy Holder: Social Security #: _____ DOB: _____

_____

PAYMENT OPTIONS:

- MasterCard & Visa are accepted
- Payment financing is available via Care Credit

- Who is your current treating physician? _____
- How many migraine headaches do you experience per month on average? _____
- How many regular headaches do you have per month on average? _____
- How painful are your migraine headaches? (Circle One Number)
  1 2 3 4 5 6 7 8 9 10
  Mild Severe
- How long do your migraine headaches usually last? _____
- Where are your migraine headaches usually located? (check all that apply)

☐ behind right eye ☐ behind left eye ☐ behind both eyes
☐ right temple ☐ left temple ☐ both temples
☐ above right eyebrow ☐ above left eyebrow ☐ above both eyebrows
☐ back of head on right ☐ back of head on left ☐ back of head both sides

- How old were you when your migraine headaches started? _____
- How would you describe your migraine headaches? (check all that apply)
  ☐ throbbing/pounding ☐ ache/pressure ☐ like a tight band ☐ other
- Do your migraine headaches awaken you at night? (check one)
  ☐ never ☐ occasionally ☐ often
- Do any of the following occur before or during your migraine headaches?
  ☐ nausea/vomiting ☐ runny nose ☐ bothered by light/noise
  ☐ blurry/double vision ☐ flashing/colored lights ☐ puffy eyelids
  ☐ other _____
- Do any of the following bring on your migraine headaches or make them worse?
  ☐ stress ☐ bright lights ☐ weather changes
  ☐ loud noise(s) ☐ heavy lifting ☐ fatigue
  ☐ other _____
- Do any of the following make your migraine headaches better?
  ☐ rest ☐ exercise ☐ quiet/darkness
  ☐ pressure on head ☐ massage ☐ vomiting
  ☐ other _____
- If you are female, do your migraine headaches change with any of the following?
  ☐ menstrual periods/pregnancy ☐birth control pills/ other hormones

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• Have you ever had a head or a neck injury requiring medical treatment?

☐no ☐yes If yes, describe _____

• Have you had your migraine headaches evaluated by a neurologist?

☐no ☐ yes If yes, by whom and when _____

• What was the diagnosis? (check all that apply)

migraine tension-type cluster other (specify) _____

• List all past tests you had for your migraine headaches: _____

_____

• List all past treatment(s) for your migraine headaches:_____

_____

• To what extent do your migraine headaches affect your quality of life? (check one)

extremely moderately very little none at all

• What activities in life have you given up because of your headaches? _____

_____

Do you currently have any of the following conditions?

	YES	NO		YES	NO		YES	NO
EYES			**ENDOCRINE**			**GENITOURINARY**		
Cataract(s)	☐	☐	Insulin dependent diabetes	☐	☐	Pain w/ urination	☐	☐
Visual disturbance(s)	☐	☐	Diabetes controlled with pills	☐	☐	Kidney/bladder infection	☐	☐
Glaucoma	☐	☐	Diabetes controlled with diet	☐	☐	Kidney stone(s)	☐	☐
Retinal Problems	☐	☐	Thyroid disease	☐	☐	Hysterectomy	☐	☐
			Parathyroid disease	☐	☐	Blood in urine	☐	☐
EAR, NOSE, THROAT			Psychiatric Disorders	☐	☐	Uterine fibroids	☐	☐
Sore throat	☐	☐						
Chronic sinus drainage	☐	☐	**CARDIAC**			**MUSCOLOSKELETAL**		
Nasal breathing issues	☐	☐	Heart Disease	☐	☐	Herniated disk	☐	☐
RESPIRATORY			Heart attack	☐	☐	Arthritis	☐	☐
Use oxygen at home	☐	☐	Angina	☐	☐	Back pain/injury	☐	☐
Emphysema	☐	☐	Heart failure					
Asthma	☐	☐	Hypertension	☐	☐	**NEUROLOGIC**		
GASTROINTESTINAL			Pacemaker			Stroke	☐	☐
Chronic nausea	☐	☐	Cardiac bypass	☐	☐	TIA (AKA “minor stroke”)	☐	☐
Chronic vomiting	☐	☐	Cardiac catheterization	☐	☐	Migraines	☐	☐
Abdominal Pain	☐	☐	Angioplasty	☐	☐	Neuropathy	☐	☐
Diarrhea	☐	☐	High cholesterol	☐	☐	**SKIN**		
Black/bloody stools	☐	☐	**HEME/LYMPH**			Moles	☐	☐
Hepatitis	☐	☐	Recent lymph node swelling	☐	☐	Poor scarring	☐	☐
Gall Stones	☐	☐	Chronic lymph node swelling	☐	☐			
Hernia(s)	☐	☐						
Spleen problems	☐	☐						

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PAST MEDICAL HISTORY:
Have you ever had any of the following?

Anemia	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Mitral valve Prolapse	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Skin Cancer	☐ Yes ☐ No
Bleeding Problem	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cancer (other)	☐ Yes ☐ No	HIV/ AIDS	☐ Yes ☐ No	Seizures	☐ Yes ☐ No

If yes to any of the above, please describe the condition:_____

_____

_____

PAST SURGICAL HISTORY (including cosmetic surgery):
Please list any previous surgery with approximate dates:

Procedure	Date	Procedure	Date

FAMILY HISTORY:
Do you have family members with any of the following conditions:

Breast Cancer	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Other Cancer	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Migraines	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Depression	☐ Yes ☐ No

If yes to any of the above, please describe the condition and identify your relation to the family member:

_____

_____

MEDICATIONS:
Please list any prescription, non-prescription, and herbal medications you are taking along with doses. If you have a long list, please bring it to us.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

DRUG ALLERGIES:_____

SOCIAL HISTORY:
Marital Status: _____ Spouse's name _____
Are you currently employed? yes _____ no ____If so, what do you do? _____
Do you smoke? yes ____no ____If so, how many packs per day? _____
If you smoked in the past, when did you quit? _____
On average, how many alcoholic drinks do you have per week? _____

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OFFICE & INSURANCE BILLING AUTHORIZATION AND NOTIFICATION

By my signature below, I am authorizing ADAM LOWENSTEIN, MD INC, MONTECITO SURGERY CENTER, and the anesthesia provider they use to bill my insurance company for services provided. Occasionally, insurance companies send the insured party (yourself) reimbursement directly for medical services provided by their doctors. In such an event, any monies received directly by me for services rendered by Dr. Lowenstein will be forwarded to this office within 2 weeks of receipt. In addition, any co-pays or deductibles will be paid in full within 2 weeks of any procedure or office visit as applicable. I further understand that Dr. Lowenstein may or may not be a participating provider with my insurance plan. As such, the allowed amount according to my insurance company for any services/procedures rendered may be less than the amount charged by ADAM LOWENSTEIN, MD INC, MONTECITO SURGERY CENTER, and the anesthesia provider they use and I acknowledge that the difference will be my responsibility. I also acknowledge and understand that there will be a fee of $25.00 (per form up to 4 pages and an additional $25.00 fee for each additional 4 pages of paperwork over the initial 4 pages) to complete any paperwork associated with my care. Finally, any appointments not canceled AT LEAST 24 HOURS prior to the scheduled time will be subject to a $100 cancellation fee. I further acknowledge that any questions regarding these matters have been answered by Dr. Lowenstein and/or his staff.

_____

Printed Name

_____

Signature

If not signed by patient, please indicate relationship to patient (e.g. spouse)

_____

Relationship

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.
• Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
• Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards. The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.
We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.
The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:
• Most uses and disclosure of psychotherapy notes;
• Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
• Disclosures that constitute a sale of PHI under HIPAA; and
• Other uses and disclosures not described in this notice.
You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.
You may have the following rights with respect to your PHI:
• The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
• The right to inspect and copy your PHI.
• The right to amend your PHI.
• The right to receive an accounting of disclosures of your PHI.
• The right to obtain a paper copy of this notice from us upon request.
• The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.
If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.
We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.
This notice if effective as of September 23, 2013, and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.
Feel free to contact the Practice Compliance Officer Susanne Engberg (805)969-9004 for more information, in person or in writing.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have been presented with a copy of Headache Surgery Specialty Center's 'Notice of Privacy Practices', detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of these 'Practices', and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

_____
Printed Name

_____ _____
Signature Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

_____
Relationship

PAIN SELF EFFICACY QUESTIONNAIRE (PSEQ)

M.K.Nicholas (1989)

NAME: _____ DATE: _____

Please rate how confident you are that you can do the following things at present, despite the pain. To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

For example:

0 1 2 3 4 5 6

Not at all Confident Completely confident

Remember, this questionnaire is not asking whether of not you have been doing these things, but rather how confident you are that you can do them at present, despite the pain.

---

1. I can enjoy things, despite the pain.

0 1 2 3 4 5 6

Not at all Confident Completely confident

2. I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.

0 1 2 3 4 5 6

Not at all Confident Completely confident

3. I can socialize with my friends or family members as often as I used to do, despite the pain.

0 1 2 3 4 5 6

Not at all Confident Completely confident

4. I can cope with my pain in most situations.

0 1 2 3 4 5 6

Not at all Confident Completely confident

5. I can do some form of work, despite the pain. ("work" includes housework, paid and unpaid work).

0 1 2 3 4 5 6

Not at all Confident Completely confident

6. I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.

0 1 2 3 4 5 6

Not at all Confident Completely confident

7. I can cope with my pain without medication.

0 1 2 3 4 5 6

Not at all Confident Completely confident

8. I can still accomplish most of my goals in life, despite the pain.

0 1 2 3 4 5 6

Not at all Confident Completely confident

9. I can live a normal lifestyle, despite the pain.

0 1 2 3 4 5 6

Not at all Confident Completely confident

10. I can gradually become more active, despite the pain.

0 1 2 3 4 5 6

Not at all Confident Completely confident

Source: Nicholas M.K. Self-efficacy and chronic pain. Paper presented at the annual conference of the British Psychological Society. St. Andrews, 1989.
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