

If you are a new patient of Dr. Green please print out and complete the **Patient Registration Form** and the **Initial Consultation Form** and bring these to your first visit. If you happen to also have headaches or chronic pain please fill out the additional **pain diagram** and **previous treatment form**. For those with headache disorders a **headache calendar** can be printed for use at any time.



## Greater Washington Headache Center

### INSURANCE INFORMATION

Primary Insurance Company:	ID#	Group #
Employer of Insured:	Cardholders Full Name:	Cardholders Work#:
Cardholders relationship to patient:	Cardholders Date of Birth:	
Secondary Insurance Company:	ID#	Group #
Employer of Insured:	Cardholders Full Name:	Cardholders Work#:
Cardholders relationship to patient:	Cardholders Date of Birth:	
IS THIS A LEGAL CASE? Yes or No	IS THIS A WORKMANS COMP CASE? Yes or No	
Date of Accident or Injury:	Employer at time of Accident or Injury:	
Automobile Insurance Company's Name:	Policy #	
Address of Automobile Insurance Company:	Claim #	
Attorney's Name:	Attorney's Phone Number:	
Attorney's Address:		

### --AUTHORIZATIONS--

**Authorization for Treatment**

I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and /or her designated providers.

**Authorization for Release of Information**

I authorize these physicians to release to my insurance carrier and its designated agents any information concerning medical care, advise, treatment or supplies provided to the patient for the purposes of administration, review, investigation or evaluation of coverage claims and utilization of services. I certify that the information that I have given is correct. I know that I have the right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

**Authorization of Insurance Benefits (as applicable to Medicare patients)**

I hereby assign payment directly to these physicians (Dr. M. Elizabeth Latimer and Dr. Jody Green ) for services covered by Medicare insurance and the Social Security Administration and Health Care Financing Administration. I assume financial responsibility for, and agree to make payment in full to these physicians for all charges for services or medical supplies furnished, and I request that payments from Medicare be made directly to the provider of services. I understand that I am financially responsible for any amounts not covered by my insurance contract and I am responsible for all costs of collection of any debt balance and any unpaid deficiency, including without limitation, attorney's fees incurred.

**Signature(Patient or Guardian):** \_\_\_\_\_

**Date:** \_\_\_\_\_

# The Greater Washington Headache Center

Phone: 301-530-9200 Fax: 301-530-9442

Web: <http://www.washingtonheadaches.com>

Name: \_\_\_\_\_ Month: \_\_\_\_\_ Year: \_\_\_\_\_

	Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Headache Severity	Morning																																
	Afternoon																																
	Evening/Night																																

Scale of 0 - 3 No pain = 0 1 2 3 = Pain as bad as it can be

**SYMPTOMATIC MEDICATIONS (Tablets/Injections/Nasal Sprays/Suppositories)**

**Instructions:**

**LIMITS:**

Name:	Dose:																																
	<b>Overall Relief</b>																																
Name:	Dose:																																
	<b>Overall</b>																																
Name:	Dose:																																
	<b>Overall</b>																																
Name:	Dose:																																
	<b>Overall</b>																																

Relief: 0 - 1 - 2 - 3    0 = None    1 = Slight Relief    2 = Moderate Relief    3 = Complete Relief

**PREVENTATIVE MEDICATIONS**

**Instructions:**

Name:	Dose:																															
Name:	Dose:																															
Name:	Dose:																															

MENSTRUAL PERIODS																																
TRIGGERS (See Back of Pg.)																																
DISABILITY FOR THE DAY																																

0 = NONE    1 = ABLE TO CARRY OUT ACTIVITIES FAIRLY WELL    2 = DIFFICULTY WITH USUAL ACTIVITY, MAY CANCEL LESS IMPORTANT ONES  
3 = HAVE TO MISS WORK (AT LEAST HALF OF THE DAY) OR GO TO BED FOR PART OF THE DAY

**PLEASE INDICATE THE OVERALL SEVERITY OF YOUR HEADACHE PROBLEM OVER THE PAST MONTH (CIRCLE ONE):**

No problem 0    1    2    3    4    5    6    7    8    9    10    Very Bad (Almost Unbearable)



**HEADACHE TRIGGERS**

Hormones

1. Menses
2. Ovulation
3. Hormone Replacement Therapy

Diet

4. Alcohol
5. Chocolate
6. Aged Cheeses
7. Monosodium Glutamate (MSG)
8. Aspartame (Nutrasweet/Equal)
9. Caffeine
10. Nuts
11. Nitrites, Nitrates
12. Citrus Fruits
13. Other

Changes

14. Weather
15. Seasons
16. Travel
17. Altitude
18. Schedule Changes
19. Sleeping Patterns (Too little/too much)
20. Diet
21. Skipping Meals

Sensory Stimuli

22. Strong Light
23. Flickering Lights
24. Odors

“Stress”

25. Let-Down Periods
26. Intense Activity
27. Loss (Death, Separation, Divorce)
28. Relationship Difficulties
29. Job Loss/Change
30. Crisis
31. Other

**EXERCISE:**

**SLEEP:**

**RELAXATION EXERCISES AND TIME FOR SELF:**

**VITAMINS/MINERALS/HERBS/SUPPLEMENTS:**

Multivitamin:

Vitamin B2: 100mg/200mg/400mg each a.m.

Vitamin E: 400IU Once/ Twice per day

Magnesium: 200Mg/400mg each a.m.

Feverfew: As per brand

Ginger Capsules: One Capsule for nausea up to 4 times per day

Migrilief is a commercial preparation of Mg, Vitamin B2, and Feverfew

Is commercially available over the internet and specialty pharmacies

Coenzyme Q 150 mg/day

## *Medication List*

If you are a headache or chronic pain patient please circle the medications that you have been treated with before. Please asterisk the ones that have helped, even if only briefly. We have listed both generic names and trade names when possible. May list any additional agents

Asprin, Empirin, Bufferin, Excedrin, Anacin

Axert

Amerge (naratriptan)

Amitriptiline (Elavil)

Antihistamines

Anacin

Bellergal

Botox, Myobloc

Calan (verapamil)

Codeine

Cafergot (ergotmine), Ergostat

Darvocet, Darvon

Decadron

Decongestants

DHE-45, Migrainol

Demerol (miperidine)

Depakote (valproate)

Duragesic (fentanyl)

Esgic, Esgic Plus

Excedrin, Excedrin Migraine

Fioricet, Fiorinal

Flexeril, cyclobenzaprine

Frova

Gabapril

Ibuprofen, Motrin, Advil

Imitrex

Inderal, propranolol

Keppra

Lamictal

Lidocaine

Lithium

Maxalt

Midrin

MS contin

Neurontin, gabapentin

Naprosyn

Naproxen sodium, Anaprox, Aleve

Oxycodone, Percocet, Percodan

Oxycontin  
Pamelor, nortriptiline  
Phrenilin, Phrenilin Forte  
Relpax  
Robaxin  
Sansert  
Stadol  
Soma  
Talwin  
Topamax, topiramate  
Tylenol, Extra strength Tylenol, Tylenol pm  
Valium  
Wigrane  
Xanax  
Zanaflex  
Zomig  
Zonegran  
Others please list

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Name: \_\_\_\_\_ Referred by Dr.: \_\_\_\_\_  
Date: \_\_\_\_\_ Dr. Address: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Dr. Phone: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ What Dr.(s) should receive a copy of your medical report? \_\_\_\_\_  
I am Right \_\_\_ Left \_\_\_ handed. Dr. Address: \_\_\_\_\_  
Dr. Phone: \_\_\_\_\_

Highest level of education: \_\_\_\_\_

Chief Complaint: Please state your problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has this been happening? \_\_\_\_\_

How often does this occur? \_\_\_\_\_ How long does it last? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

If due to an accident, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Work related? Yes \_\_\_\_\_ No \_\_\_\_\_ Motor vehicle accident? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of accident: \_\_\_\_\_ Driver \_\_\_\_\_ Passenger \_\_\_\_\_

Did you stop work because of this accident? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, when? \_\_\_\_\_

Please list the doctors who treated you:

Primary or family physician \_\_\_\_\_

Gynecologist \_\_\_\_\_

Other \_\_\_\_\_

Any prior history of major injury or accident? \_\_\_\_\_

**Medications**

Please list your present medication(s): Please list previous medications you are no longer taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medication, allergies or drugs you can not take: \_\_\_\_\_

**Habits**

How much alcohol do you drink? \_\_\_\_\_ How much do you smoke? \_\_\_\_\_

How much caffeinated coffee do you drink per day? \_\_\_\_\_

How many caffeinated soft drinks do you drink? \_\_\_\_\_

**Medical / Surgeries(Describe)**

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**Medical Illnesses (Describe)**

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<b>Family History</b>	<b>alive</b>	<b>age</b>	<b>health/illnesses</b>	<b>died</b>	<b>age</b>	<b>cause</b>
Father	_____	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____	_____
Spouse	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

**Work History**

Present Job: \_\_\_\_\_  
 How long have you worked at this job? \_\_\_\_\_

Have you lost work time because of your illness or accident? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If so, please give dates: From: \_\_\_\_\_ to \_\_\_\_\_

Is your present job mostly:

Sedentary (sitting) _____	Require much lifting _____
Hard manual work _____	Keyboard(computer) time _____
All or much walking _____	Telephone time _____
Require much bending _____	

**Review of symptoms:**

**General**

Easily fatigued	Yes _____	No _____	<b>Comments</b>
Trouble sleeping	Yes _____	No _____	
Coldness (feel cold when others are comfortable)	Yes _____	No _____	
Cold limbs (feet, hands)	Yes _____	No _____	
Lymph nodes, swollen glands	Yes _____	No _____	
Skin rash	Yes _____	No _____	
Easy Bruising	Yes _____	No _____	

**Gastrointestinal**

Bloating	Yes _____	No _____
Constipation	Yes _____	No _____
Diarrhea	Yes _____	No _____
Irritable bowel syndrome	Yes _____	No _____
Colitis	Yes _____	No _____
Nausea/vomiting	Yes _____	No _____
Ulcers	Yes _____	No _____
Hepatitis	Yes _____	No _____
Cirrhosis	Yes _____	No _____
Bleeding from bowel	Yes _____	No _____

**Comments**

**Joints**

Arthritis	Yes _____	No _____
Osteoarthritis	Yes _____	No _____
Rheumatoid-Arthritis	Yes _____	No _____
Scoliosis	Yes _____	No _____
Joint pain:	Yes _____	No _____
Shoulder	Yes _____	No _____
Elbow	Yes _____	No _____
Wrist	Yes _____	No _____
Hip	Yes _____	No _____
Knee	Yes _____	No _____
Ankle	Yes _____	No _____
Joint swelling	Yes _____	No _____
Joint surgery	Yes _____	No _____

Date \_\_\_\_\_ Specify: \_\_\_\_\_

**Endocrine**

Diabetes Mellitus	Yes _____	No _____
Thyroid Discasc / Surgery	Yes _____	No _____
Hormone replacement	Yes _____	No _____
Estrogen	Yes _____	No _____
Pituitary Failure	Yes _____	No _____
Hypoglycemia	Yes _____	No _____

**Comments**

Medication \_\_\_\_\_  
Mcdication \_\_\_\_\_  
Date Started \_\_\_\_\_  
(Month/Year)

**Hematology**

Anemia	Yes _____	No _____
Iron Replacement	Yes _____	No _____
B12 deficiency	Yes _____	No _____
Transfusion	Yes _____	No _____
Lymphoma	Yes _____	No _____
Hodgkin's Disease	Yes _____	No _____
Leukemia	Yes _____	No _____

**Genital/Urinary**

**For woman**

Menstrual Period \_\_\_\_\_  
Periods are \_\_\_\_\_  
Post-Menstrual \_\_\_\_\_  
Breast Cancer \_\_\_\_\_

Regular _____	Irregular _____
Heavy _____	Light _____
Hysterectomy _____	Endometriosis _____
Yes _____	No _____

Breast fibrocystic disease \_\_\_\_\_ Biopsy Yes \_\_\_\_\_ No \_\_\_\_\_  
 Pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

**For Men**

Impotence Yes \_\_\_\_\_ No \_\_\_\_\_  
 Prostate Cancer Yes \_\_\_\_\_ No \_\_\_\_\_  
 Prostate Enlargement Yes \_\_\_\_\_ No \_\_\_\_\_  
 Prostate Surgery Yes \_\_\_\_\_ No \_\_\_\_\_

**Neurologic**

Have you had a:  
 Stroke Yes \_\_\_\_\_ No \_\_\_\_\_  
 TIA Yes \_\_\_\_\_ No \_\_\_\_\_  
 Seizure Yes \_\_\_\_\_ No \_\_\_\_\_  
 Parkinson's Yes \_\_\_\_\_ No \_\_\_\_\_  
 Head Injury Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have weakness:  
 In general Yes \_\_\_\_\_ No \_\_\_\_\_  
 Arms Yes \_\_\_\_\_ No \_\_\_\_\_  
 Legs Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have loss of feeling in:  
 One side Yes \_\_\_\_\_ No \_\_\_\_\_  
 Legs Yes \_\_\_\_\_ No \_\_\_\_\_

Do you experience:  
 Loss of balance Yes \_\_\_\_\_ No \_\_\_\_\_  
 Dizziness Yes \_\_\_\_\_ No \_\_\_\_\_  
 Tremor (shaking) Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have:  
 A change in memory Yes \_\_\_\_\_ No \_\_\_\_\_  
 Attention deficit Yes \_\_\_\_\_ No \_\_\_\_\_  
 Learning disabilities Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have headaches: Yes \_\_\_\_\_ No \_\_\_\_\_

**Infectious Disease**

Have you had  
 Tuberculosis Yes \_\_\_\_\_ No \_\_\_\_\_  
 AIDS Yes \_\_\_\_\_ No \_\_\_\_\_  
 A positive HIV test Yes \_\_\_\_\_ No \_\_\_\_\_  
 Syphilis Yes \_\_\_\_\_ No \_\_\_\_\_  
 Gonorrhea Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been treated for any of these conditions? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, with what drug? \_\_\_\_\_

**Head/Face/Neck**

Change of vision Yes \_\_\_\_\_ No \_\_\_\_\_  
 Loss of vision Yes \_\_\_\_\_ No \_\_\_\_\_  
 L eye, R eye, both Yes \_\_\_\_\_ No \_\_\_\_\_  
 Double vision Yes \_\_\_\_\_ No \_\_\_\_\_  
 Loss of hearing Yes \_\_\_\_\_ No \_\_\_\_\_

Loss of smell Yes \_\_\_\_\_ No \_\_\_\_\_  
 Trouble swallowing Yes \_\_\_\_\_ No \_\_\_\_\_  
 Drooping Eyelids Yes \_\_\_\_\_ No \_\_\_\_\_

**Pulmonary**

Shortness of breath Yes \_\_\_\_\_ No \_\_\_\_\_  
 Difficulty breathing Yes \_\_\_\_\_ No \_\_\_\_\_  
 With exercise Yes \_\_\_\_\_ No \_\_\_\_\_  
 Coughing Now Yes \_\_\_\_\_ No \_\_\_\_\_  
 Chronic Yes \_\_\_\_\_ No \_\_\_\_\_  
 Coughing Blood Yes \_\_\_\_\_ No \_\_\_\_\_  
 Asthma Yes \_\_\_\_\_ No \_\_\_\_\_  
 Pulmonary embolism Yes \_\_\_\_\_ No \_\_\_\_\_  
 (blood clot in lung)

**Cardiac**

Chest pain Yes \_\_\_\_\_ No \_\_\_\_\_  
 At rest Yes \_\_\_\_\_ No \_\_\_\_\_  
 With Activity Yes \_\_\_\_\_ No \_\_\_\_\_  
 Irregular heartbeats(palpitations) Yes \_\_\_\_\_ No \_\_\_\_\_  
 High blood pressure Yes \_\_\_\_\_ No \_\_\_\_\_  
 Heart Surgery Yes \_\_\_\_\_ No \_\_\_\_\_

**Mental Health**

Serious Depression Yes \_\_\_\_\_ No \_\_\_\_\_  
 Psychiatric Hospitalization Yes \_\_\_\_\_ No \_\_\_\_\_  
 Dates of hospitalization \_\_\_\_\_  
 Name of hospital \_\_\_\_\_  
 Diagnosis \_\_\_\_\_  
 Other psychiatric diagnosis? \_\_\_\_\_  
 (Obsessive-compulsive, schizophrenia, anxiety disorder, panic attacks, manic depressive illness)

**Cancer**

Have you had cancer Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please describe \_\_\_\_\_.

I attest that the above information is accurate and true to the best of my knowledge

Signature \_\_\_\_\_ Date \_\_\_\_\_.

Printed Name \_\_\_\_\_

I attest that I have reviewed the above information

Signature \_\_\_\_\_ Date \_\_\_\_\_.

# PATIENT PAIN ASSESSMENT FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_ 20\_\_\_\_

## Pain Diagram

At this time, where is your pain?

Please mark on the drawings the areas where you feel pain (circle or mark with crosses)

