Advanced Pain & Spine Institute OF MONTANA

2835 Fort Missoula Road, Suite 102
Missoula, MT 59808

P: (406)541-PAIN (7246)
F: (406)721-8298

www.advancedpainandspine.com

Dear Patient: _____,

Thank-you for choosing Advanced Pain & Spine Institute of Montana, P.C. to assist you in your pain management needs. Your initial appointment is for a consultation with the provider indicated below. Some office procedures can be performed the same day if indicated, but most in-office and all out-of-office procedures will be scheduled for a later date. In addition, **medications will not be prescribed on your first visit.**

PLEASE COMPLETE THIS ENTIRE PACKET PRIOR TO YOUR ARRIVAL. Failure to complete this paperwork prior to your check-in time will result in cancellation and re-scheduling of your consultation. Your thorough completion of this packet will allow us to more efficiently address your pain management needs.

Please bring this completed packet along with your insurance card(s) and a photo ID to your first appointment. WE ASK THAT YOU NOT MAIL THESE ITEMS TO OUR OFFICE. You will be required to verify your demographic information, review your medication list, if applicable and fill out a Review of Systems form at each visit. **You will be required to arrive 30 minutes prior to your initial appointment and 15 minutes prior to subsequent appointments** to allow time for your information to be verified and entered in to our Electronic Health Record system. If you arrive later than this your appointment may need to be re-scheduled.

Your appointment is scheduled on _____ / _____ / _____ with: Dr. Patrick Danaher
Dr. Steve Kemple
Autum Howell, CFNP
Katelyn Stetzner, CFNP

*Please arrive "check-in" at _____:_____ a.m. / p.m. for your _____:_____ a.m. / p.m. appointment.

□ Missoula office
2835 Fort Missoula Road, Suite 102
Missoula, MT 59804
Building #3

□ Hamilton office (Mondays only)
1150 Westwood Dr. Ste E
Hamilton, MT 59840

If you have any questions/concerns prior to your appointment, feel free to give us a call.

Sincerely,

The Providers and Staff of Advanced Pain & Spine Institute of Montana

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Dear Patient,

In the instance that you would need to cancel your appointment, we ask that as a courtesy to the many other patients waiting to be seen in our office that you contact our office at least 24 hours prior to your scheduled appointment. Patients who fail to present for a scheduled appointment without contacting our office will be considered a NO SHOW (please refer to our "NO SHOW POLICY" for further information). **You will be required to arrive 30 minutes prior to your consultation and 15 minutes prior to any other appointment** to allow time for your information to be verified and entered in to our Electronic Health Record system.

The providers of Advanced Pain & Spine Institute of Montana are pleased to provide services for your pain management needs. We would like to make you aware that you will receive a bill for these services separate from that of your other medical providers.

If you are uninsured or this is related to a motor vehicle accident or legal suit, you will be considered a self pay and a minimum payment of $125 for office visits, $225 for consultations or $500 for injections is required in advance. If we can verify with a claims adjuster that the motor vehicle insurance has accepted medical responsibility then we will attempt to bill them for services. If they do not pay in a timely matter the balance due will be made the patients responsibility. Please contact our office at least 48 hours prior to your appointment/procedure to make this payment or provide this information. We offer a 10% cash discount for all services that are paid in full at time of service. A NSF fee of $30 will be charged for all returned checks.

We are contract providers for Medicare (including Advantage Plans), Medicaid (Montana & Idaho), Blue Cross Blue Shield, Allegiance/Cigna, Pacific Source and New West. We are also able to accept Tricare, VA & Champ VA insurance. If your are covered under any other plan than those listed above, we are not able to adjust your balance after your insurance company makes payment as each insurance company determines what they will cover for a particular appointment/procedure independently.

We suggest that regardless of your insurance plan, you ensure that you fully understand your plan coverage before services are performed and obtain any pre-authorizations needed. This will keep you informed and fully prepared for any balance that will be your responsibility. As a courtesy, we will submit a claim to your insurance plan if you have provided that information to the facility where your services are performed. **Please be sure to verify your insurance information at check-in for every appointment/procedure**. Again, we submit claims as a courtesy, therefore, if payment is excessively delayed, it will be your responsibility to keep your account current and work with your insurance company to rectify the issue. All Co-pays are due and expected at time of service.

We appreciate your understanding of our billing practices and look forward to providing you with high quality pain management services. If you are interested in receiving an estimate for your pain management services or have any questions about your bill, please feel free to call our billing office at (406)728-8420.

Sincerely,
The Providers and Staff of Advanced Pain & Spine Institute of Montana

Advanced Pain & Spine Institute OF MONTANA

NAME (LAST, FIRST, MIDDLE)			
HOME PHONE	CELL PHONE	WORK PHONE	☐ OK TO LEAVE MESSAGE
☐ MALE ☐ FEMALE	DATE OF BIRTH	AGE	SOCIAL SECURITY #
ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER	OCCUPATION	EMPLOYER PHONE	
EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ SELF EMPLOYED ☐ UNEMPLOYED ☐ ACTIVE MILITARY ☐ RETIRED ☐ STUDENT			
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED	E-MAIL		
EMERGENCY CONTACT	RELATIONSHIP	PHONE	
IS YOUR CONDITION A RESULT OF A WORKER'S COMPENSATION OR PERSONAL INJURY/ACCIDENT? ☐ YES ☐ NO IF YES, PLEASE PROVIDE:			
CLAIM ADJUSTER NAME	CLAIM #	DATE OF INJURY	
NATURE OF INJURY	PHONE	FAX	
ARE YOU INVOLVED IN A LEGAL CASE REGARDING THE ABOVE INJURY/ACCIDENT? ☐ YES ☐ NO IF YES, PLEASE PROVIDE:			
NAME OF ATTORNEY	PHONE	FAX	
ADDRESS	CITY	STATE	ZIP CODE
PRIMARY INSURANCE INFORMATION: ☐ GROUP/MEDICAL ☐ WORKER'S COMPENSATION ☐ AUTO ☐ OTHER			
INSURANCE COMPANY NAME	EFFECTIVE DATE	PHONE	
ADDRESS	CITY	STATE	ZIP CODE
SUBSCRIBER OF INSURANCE POLICY (LAST, FIRST, MIDDLE)	SOCIAL SECURITY #		
DATE OF BIRTH	INSURANCE ID #	GROUP #	
EMPLOYER	EMPLOYER PHONE	RELATIONSHIP TO SUBSCRIBER	
SECONDARY INSURANCE INFORMATION: ☐ GROUP/MEDICAL ☐ WORKER'S COMPENSATION ☐ AUTO ☐ OTHER			
INSURANCE COMPANY NAME	EFFECTIVE DATE	PHONE	
ADDRESS	CITY	STATE	ZIP CODE
SUBSCRIBER OF INSURANCE POLICY (LAST, FIRST, MIDDLE)	SOCIAL SECURITY #		
DATE OF BIRTH	INSURANCE ID #	GROUP #	
EMPLOYER	EMPLOYER PHONE	RELATIONSHIP TO SUBSCRIBER	

I authorize treatment of the person named above as patient and agree that I am financially responsible for all charges incurred through the office of Advanced Pain & Spine Institute of Montana regardless of insurance or third party liability. I hereby assign payment of insurance benefits to Advanced Pain & Spine Institute of Montana, when applicable. I understand that Advanced Pain & Spine Institute of Montana has the right to refuse or accept assignment of such benefits. If these benefits are paid directly to me, I agree to forward all payments that are owed to Advanced Pain & Spine Institute of Montana. I understand that is is my responsibility to contact my insurance company to verify coverage, benefits and to obtain pre-authorization prior to services being rendered.

I hereby authorize Advanced Pain & Spine Institute of Montana to release any applicable personal or medical information contained in my records for treatment, payment and healthcare operations. I hereby acknowledgethat I have received a copy of the Notice of Privacy Practices and am aware that I can request a copy of the Notice at any time.

I certify that the above information I have provided is correct and that I have read and fully understand all sections of the form and affix my signature as patient or patient's legal representative as acknowledgment of all sections.

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Print Name Relationship to Patient

AUTHORIZATIONS:

I hereby authorize _____ to:

(Name of person you are authorizing to discuss/obtain your information marked below, i.e. spouse, child, friend, etc.)

_____ Discuss financial information

INITIAL

_____ Discuss medical information and care

INITIAL

Our office now offers easy, secure on-line access to your medical information.

NEXTGEN®
Patient Portal

- Make appointment requests
- Check your appointment date & time
- Receive appointment reminders
- View/print your medications
- Request medication refills
- View/print your test results and other medical records
- Communicate with our office staff

Give us a call today or provide us with your e-mail address at your next appointment!

Advanced Pain & Spine Institute OF MONTANA

PAIN MANAGEMENT QUESTIONNAIRE

Date: _____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Referring Physician: _____

Primary Care Physician: _____

Pharmacy: _____

Have you had any imaging of the area you are here to have evaluated: □ Yes □ No

If Yes, When: _____/_____/_____

Where: _____

Reason for appointment/Reason you were referred:

□ Back Pain □ Neck Pain □ Arm/Leg Pain □ Shingles

□ Abdominal Pain □ Cancer □ Headaches □ CRPS □ Other: _____

****Please fill out the rest of this form only for the pain associated with the area you marked above****

- Have you had this pain before: □ Yes □ No If Yes, When: _____
- Please describe how your pain began: _____
- Do you have weakness of your extremities: □ Yes □ No
  If Yes, Where: □ Left Leg □ Right Leg □ Left Arm □ Right Arm
- Do you have numbness (inability to feel): □ Yes □ No
  If Yes, Where: _____
- Do you have tingling: □ Yes □ No If Yes, Where: _____
- Do you have loss of control of your: □ Bowel □ Bladder
  If Yes,
  - Have you experienced this for a long time: □ Yes □ No
  - Does it only happen with coughing/sneezing: □ Yes □ No
  - Is it difficult to go: □ Yes □ No
  - Have you had any accidents: □ Yes □ No If Yes, How often: _____

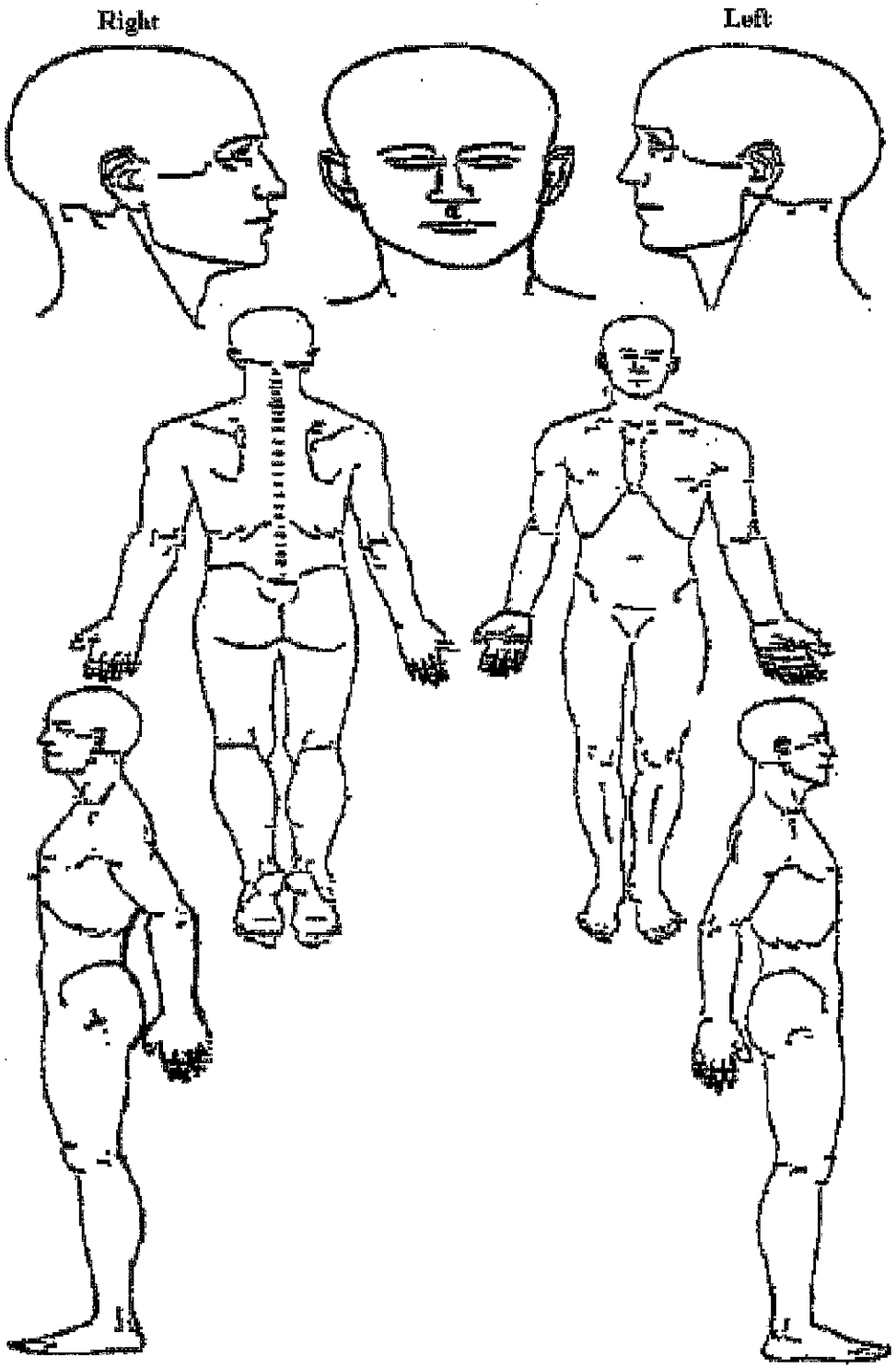
Patient Name: _____

- Does the pain interrupt your sleep: □ Yes □ No
- Have you had any un-purposeful □ Weight loss □ Weight gain
  If Yes, How much: _____ pounds When did this occur: _____
- Do you wake up at night sweating or soaking wet: □ Yes □ No
  If Yes, How often: _____ How long have you been experiencing: _____
- Have you been seen by another pain clinic in the past: □ Yes □ No
  If Yes, When: _____/_____/_____ - _____/_____/_____
  Who/Where: _____
- Have you had any previous pain management injections: □ Yes □ No
  If Yes, What type: _____ Did it help: □ Yes □ No
  _____ Did it help: □ Yes □ No
  _____ Did it help: □ Yes □ No
- Have you had physical therapy: □ Yes □ No
  If Yes, When: _____/_____/_____ - _____/_____/_____
  Who/Where: _____
  Did you learn a home therapy program: □ Yes □ No
- Have you seen a chiropractor: □ Yes □ No
  If Yes, When: _____/_____/_____ - _____/_____/_____
  Who/Where: _____
- Have you seen a pain psychologist: □ Yes □ No
  If Yes, When: _____/_____/_____ - _____/_____/_____
  Who/Where: _____
  Did you learn: □ Biofeedback □ Coping skills □ Relaxation methods
- Have you had acupuncture: □ Yes □ No
  If Yes, When: _____/_____/_____ Did it help: □ Yes □ No
- Have you used a TENS unit (electrical stimulation of the skin): □ Yes □ No
  If Yes, When: _____/_____/_____ Did it help: □ Yes □ No

Patient Name: _____

Pain Location-

Indicate the location of your **PAIN** by using an **X** on the diagram below:



Patient Name: _____

Addressing the Personal Side of Living with Chronic Pain

As an individual living with persistent chronic pain every day, you are fully aware that your PAIN does NOT just affect you physically. Chronic pain touches every part of your life. Your pain affects you emotionally, mentally and spiritually. Living with pain has an impact on your roles in life, your relationships, your work, your hobbies, your recreational activities and the overall quality of your life. Therefore, for us to effectively address helping you manage your pain, please answer the following questions.

1. Have you struggled to manage your pain by using the "ole stiff upper lip" or "tough it out" method? □ Yes □ No
2. Have you lost your job, missed a significant amount of work or stopped physical or recreational activities? □ Yes □ No
3. Do you feel you have lost meaning and purpose in your life? □ Yes □ No
4. Has living with pain changed your roles in life as an employee, spouse, parent, etc.? □ Yes □ No
5. Do you feel you have failed or let other down by not being able to "DO" as you once did? □ Yes □ No
6. Do you feel your pain is often in control of your life:? □ Yes □ No
7. Do you find your moods bouncing around, at times you feel depressed, angry or anxious? □ Yes □ No
8. Do family/friends seem to struggle to understand what it is like for you to live with chronic pain? □ Yes □ No
9. Do you feel judged at times? □ Yes □ No
10. Do you struggle sometimes making a decision about an activity worrying that it will result in a "flare up"? □ Yes □ No
11. Have you noticed that as your stress level increases so does your pain? □ Yes □ No
12. Do you find it difficult to "relax" or "calm" yourself as you go through your day with pain? □ Yes □ No

Please share with us any comments you have regarding the screening questions or any personal concerns or difficulties you have living with your pain:

_____

_____

_____

_____

Patient Name: _____

BACK PAIN

- **Is your walking limited:** □ **Yes** □ **No**

  If yes, how far can you walk without stopping to rest: _____ **blocks / miles**

- **Does bending over holding on to a shopping cart, etc. allow you to walk farther:** □ **Yes** □ **No**

- **What percentage in in the back:** _____% **What percentage is in the leg(s):** _____%

Please check all that apply.

Concern: back pain

Onset:

Duration:

Severity:

Status:
- ○ Changing
- ○ Improving
- ○ Fluctuating
- ○ Resolved
- ○ Stable
- ○ Worse

Frequency:
- ○ Intermittently
- ○ Occasional
- ○ Persistent
- ○ Rare

Location of Pain:
- ☐ Upper back
- ☐ Neck
- ☐ Mid back
- ☐ Thighs
- ☐ Lower back
- ☐ Gluteal area
- ☐ Left flank
- ☐ Right flank
- ☐ Arms
- ☐ Legs

Other:

Radiation of Pain:
- ☐ None
- ☐ Back
- ☐ Dermatomally anterior
- ☐ Left ankle
- ☐ Right ankle
- ☐ Left arm
- ☐ Right arm
- ☐ Left calf
- ☐ Right calf
- ☐ Left foot
- ☐ Right foot
- ☐ Left thigh
- ☐ Right thigh

Other:

Quality:
- ☐ Ache
- ☐ Piercing
- ☐ Burning
- ☐ Sharp
- ☐ Deep
- ☐ Shooting
- ☐ Diffuse
- ☐ Stabbing
- ☐ Discomforting
- ☐ Superficial
- ☐ Dull
- ☐ Throbbing
- ☐ Localized
- ☐ Numbness

Other:

Context: (what caused onset of pain)
- ☐ Bending forward
- ☐ Pulling
- ☐ Bending over
- ☐ Pushing
- ☐ Blow from behind
- ☐ Sitting
- ☐ Hard fall
- ☐ Sports:
- ☐ Inflam bowel disease
- ☐ Sudden movement
- ☐ Lifting a heavy object
- ☐ Trauma
- ☐ Lying down
- ☐ Twisting movement
- ☐ MVA
- ☐ Walking
- ☐ No injury
- ☐ Walking up stairs

Other:

Trauma:

Type:

Where:

When: Date: / /

☐ Previously injured

Aggravated By:
- ☐ Nothing
- ☐ Ascending stairs
- ☐ Extension
- ☐ Running
- ☐ Bending
- ☐ Flexion
- ☐ Sitting
- ☐ Changing positions
- ☐ Jumping
- ☐ Sneezing
- ☐ Coughing
- ☐ Lifting
- ☐ Standing
- ☐ Daily activities
- ☐ Lying/rest
- ☐ Twisting
- ☐ Defecation
- ☐ Rolling over in bed
- ☐ Walking
- ☐ Descending stairs
- ☐ Pushing

Other:

Relieved By:
- ☐ Nothing
- ☐ Exercise
- ☐ Lying down
- ☐ Pain meds/drugs
- ☐ Heat
- ☐ Massage
- ☐ Physical therapy
- ☐ Ice
- ☐ Movement
- ☐ Spontaneously
- ☐ Injection:
- ☐ OTC medications:
- ☐ Stretching
- ☐ Rest
- ☐ Sitting

Other:

Patient Name: _____

ABDOMINAL PAIN

Please check all that apply.

Abdominal Pain Quick Visit

Concern: abdominal pain

Onset: _____ Pain Scale: _____

Severity of Symptoms: ○ mild ○ moderate ○ severe ○ incapacitating

Frequency: ○ constant ○ recurring ○ intermittent ○ nocturnal

Status: ○ improving ○ no change ○ worse ○ resolved

Location

- ☐ diffuse
- ☐ epigastric
- ☐ hypogastric
- ☐ midline
- ☐ peri-umbilical
- ☐ right upper quadrant
- ☐ right lower quadrant
- ☐ left upper quadrant
- ☐ left lower quadrant
- other: _____

Radiation

- ☐ back
- ☐ chest
- ☐ flank
- ☐ groin
- ☐ neck
- ☐ pelvis
- ☐ perineum
- ☐ rectum
- ☐ shoulder
- other: _____

Quality

- ☐ achy
- ☐ burning
- ☐ colicky
- ☐ dull
- ☐ sharp
- ☐ stabbing
- ☐ throbbing
- other: _____

Context (what caused onset of pain)

No	Yes	
○	○	after bowel movement
○	○	after meals
○	○	menses
○	○	on urination
○	○	recent antibiotic use
○	○	recent foreign travel

other negatives: _____
other positives: _____
comments: _____

Aggravated by

No	Yes	
○	○	alcohol
○	○	anxiety
○	○	bowel movement
○	○	constipation
○	○	exercise
○	○	intercourse
○	○	milk / dairy products
○	○	movement

☐ nothing

other negatives: _____
other positives: _____
comments: _____

Relieved by

No	Yes	
○	○	analgesics
○	○	antacids
○	○	bowel movement
○	○	change in position
○	○	eructation
○	○	flatus
○	○	H2 blockers
○	○	OTC meds
○	○	proton pump inhibitors
○	○	rest
○	○	vomiting

☐ nothing

other negatives: _____
other positives: _____
comments: _____

Associated Symptoms / Pertinent Negatives

Neg	Pos		Neg	Pos		Neg	Pos		Neg	Pos		Neg	Pos	
○	○	back pain	○	○	diaphoresis	○	○	fever	○	○	jaundice	○	○	vaginal bleeding
○	○	bloating	○	○	diarrhea	○	○	flank pain	○	○	lightheadedness	○	○	vaginal discharge
○	○	blood in stool	○	○	dizziness	○	○	flatulence	○	○	myalgia	○	○	vomiting
○	○	change in appetite	○	○	dyspnea	○	○	heartburn	○	○	nausea	○	○	weight gain
○	○	constipation	○	○	eructation	○	○	hematuria	○	○	rash	○	○	weight loss

☐ No associated symptoms
☐ No pertinent negatives
☐ All other negative

other negatives: _____
other positives: _____
comments: _____

Comments: _____

Review of Systems

Constitutional	Neg	Pos	Gastrointestinal	Neg	Pos	Gastrointestinal	Neg	Pos	Genitourinary	Neg	Pos	Reproductive	Neg	Pos
chills / rigors	○	○	abdominal pain	○	○	melena	○	○	dysuria	○	○	dysmenorrhea	○	○
fatigue	○	○	anorexia	○	○	nausea	○	○	flank pain	○	○	dyspareunia	○	○
fever	○	○	constipation	○	○	reflux	○	○	frequent urination	○	○	menorrhagia	○	○
			diarrhea	○	○	vomiting	○	○	hematuria	○	○	vaginal discharge	○	○
			hematemesis	○	○	weight loss	○	○						
			hematochezia	○	○									

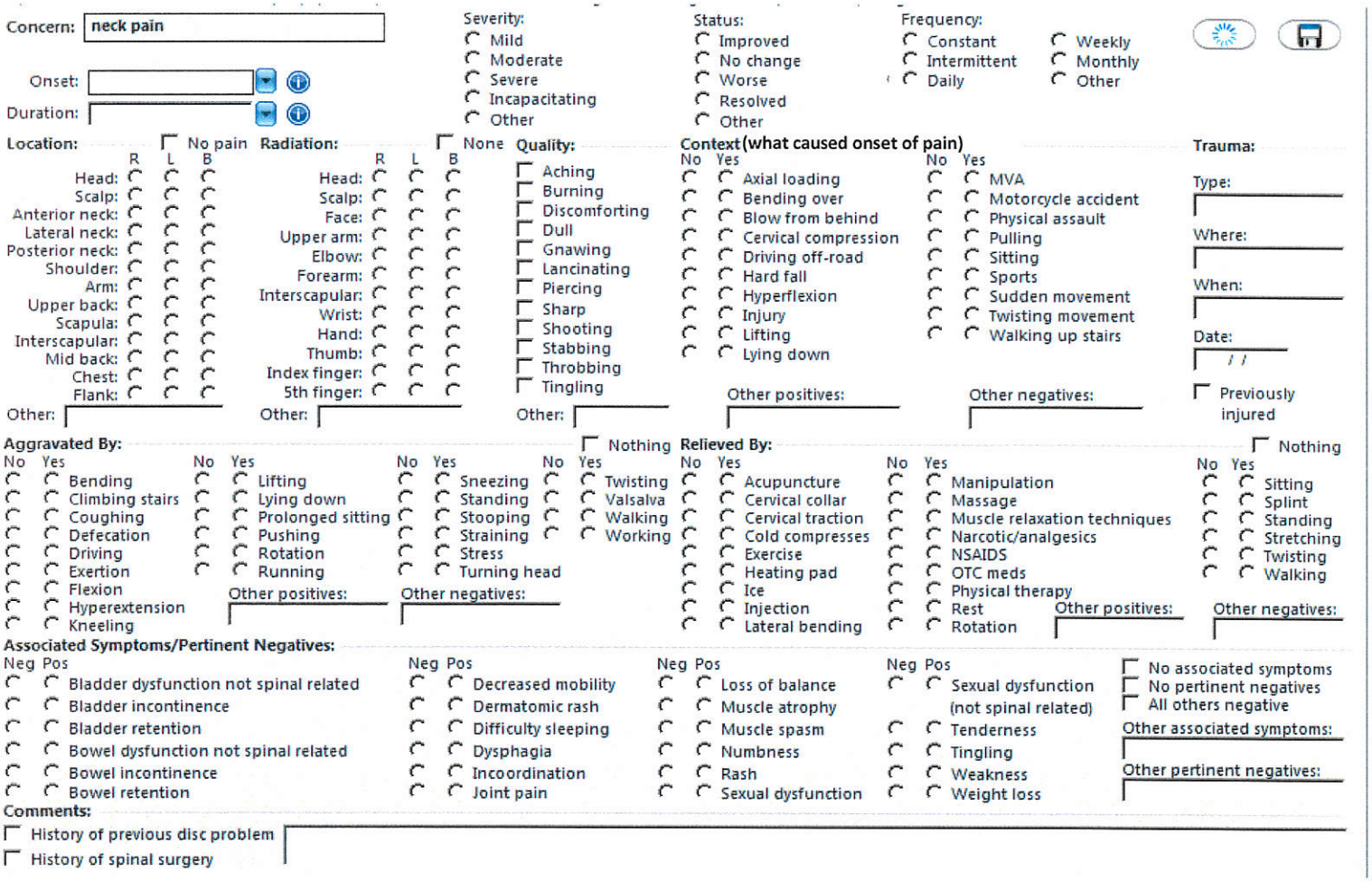
OK Cancel

Patient Name: _____

NECK PAIN

- **What percentage in in the neck: _____%**
- **What percentage is in the arm(s): _____%**

Please check all that apply.



Patient Name: _____

ARM/LEG PAIN

- **Does your affected extremity change color:** □ **Yes** □ **No**
- **Does your affected extremity feel:** □ **warmer** □ **colder**
- **Does your affected extremity swell:** □ **Yes** □ **No**
- **Does light touch worsen your pain (putting on socks, sheets on the bed):** □ **Yes** □ **No**
- **Have you noticed** □ **hair** □ **nail** **growth on the affected extremity:** □ **Yes** □ **No**

Please check all that apply.

Concern: musculoskeletal pain

Onset:

Duration:

Severity:

Frequency:
- Intermittent
- Occasional
- Constant
- Rare

Status:
- Changing
- Fluctuating
- Improving
- Resolved
- Stable
- Worse

Location:
- Right / Left / Bilateral
- Ankle / Hand / Shoulder
- Elbow / Knee / Wrist
- Foot — Qualifier:

Other:

- Multiple bone/joint locations
- Multiple muscle locations

Radiation:
- No
- Yes

Radiates to:

Quality:
- Aching
- Burning
- Dull
- Piercing
- Sharp
- Throbbing

Other:

What caused onset of pain:
- No injury
- Injury
- Sports injury:
- MVA — Details

Other:

Trauma:
- Type:
- Where:
- When:
- Date: / /

Aggravated By:
- Bending / Lifting / Nothing
- Climbing stairs / Movement / Sitting
- Descending stairs / Pushing / Standing
- Walking

Other:

Relieved By:
- Brace/splint / Ice / Mobility / Nothing
- Elevation / Injection / OTC medicines: / Physical therapy
- Exercise / Massage / Rest
- Heat / Pain/RX meds / Stretching

Other:

Associated Symptoms/Pertinent Negatives:

- No associated symptoms
- No pertinent negatives
- All others negative

Neg	Pos		Neg	Pos		Neg	Pos	
○	○	Bruising	○	○	Limping	○	○	Spasms
○	○	Crepitus	○	○	Locking	○	○	Swelling
○	○	Decreased mobility	○	○	Nocturnal awakening	○	○	Tingling in the arms
○	○	Difficulty initiating sleep	○	○	Nocturnal pain	○	○	Tingling in the legs
○	○	Joint instability	○	○	Numbness	○	○	Weakness
○	○	Joint tenderness	○	○	Popping			

Other associated symptoms:

Other pertinent negatives:

- ADLs
- Functional Limitations

Comments:

Hand dominance:
- Right / Left / Ambidextrous

Patient Name: _____

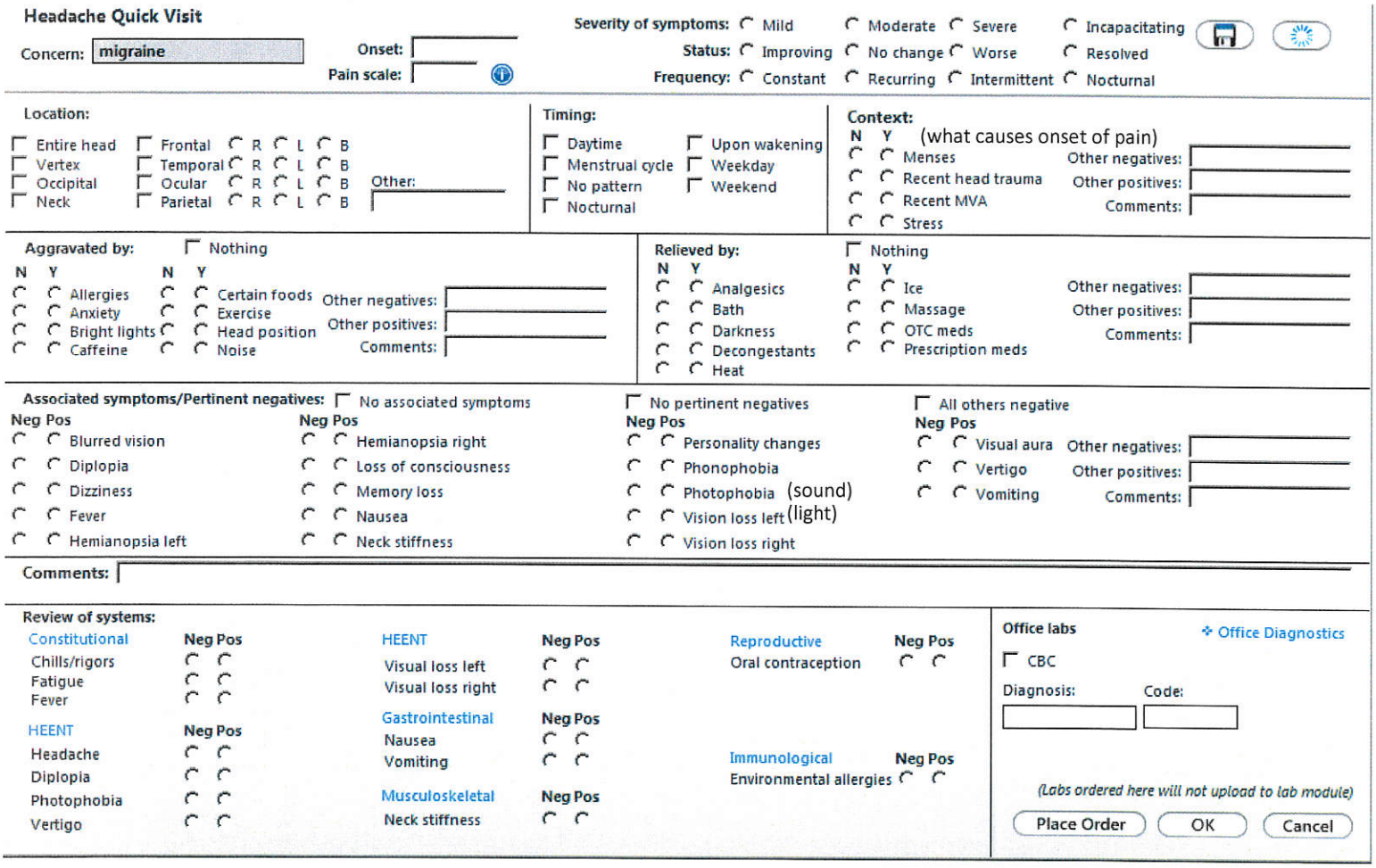
HEADACHES

- **Are there any signs that your headache is going to happen: □ Yes □ No**

  If Yes, what are the signs: _____

- **How many hours do your headaches typically last? _____**

Please check all that apply.



Headache Quick Visit

Concern: migraine Onset: Pain scale:

Severity of symptoms: Mild Moderate Severe Incapacitating
Status: Improving No change Worse Resolved
Frequency: Constant Recurring Intermittent Nocturnal

Location:
Entire head; Vertex; Occipital; Neck; Frontal; Temporal; Ocular; Parietal — R L B
Other:

Timing:
Daytime; Menstrual cycle; No pattern; Nocturnal; Upon wakening; Weekday; Weekend

Context: (what causes onset of pain)
N Y
Menses; Recent head trauma; Recent MVA; Stress
Other negatives:
Other positives:
Comments:

Aggravated by: Nothing
N Y
Allergies; Anxiety; Bright lights; Caffeine; Certain foods; Exercise; Head position; Noise
Other negatives:
Other positives:
Comments:

Relieved by: Nothing
N Y
Analgesics; Bath; Darkness; Decongestants; Heat; Ice; Massage; OTC meds; Prescription meds
Other negatives:
Other positives:
Comments:

Associated symptoms/Pertinent negatives: No associated symptoms
Neg Pos
Blurred vision; Diplopia; Dizziness; Fever; Hemianopsia left; Hemianopsia right; Loss of consciousness; Memory loss; Nausea; Neck stiffness

No pertinent negatives
Neg Pos
Personality changes; Phonophobia; Photophobia (sound); Vision loss left (light); Vision loss right

All others negative
Neg Pos
Visual aura; Vertigo; Vomiting
Other negatives:
Other positives:
Comments:

Comments:

Review of systems:

Constitutional — Neg Pos
Chills/rigors; Fatigue; Fever

HEENT — Neg Pos
Headache; Diplopia; Photophobia; Vertigo

HEENT — Neg Pos
Visual loss left; Visual loss right

Gastrointestinal — Neg Pos
Nausea; Vomiting

Musculoskeletal — Neg Pos
Neck stiffness

Reproductive — Neg Pos
Oral contraception

Immunological — Neg Pos
Environmental allergies

Office labs ❖ Office Diagnostics
CBC
Diagnosis: Code:
(Labs ordered here will not upload to lab module)
Place Order OK Cancel

Chronic Migraine Screener

What is Chronic Migraine?

Chronic Migraine is a condition defined as 15 or more headache days a month with each headache lasting 4 hours or more per day. At least half of the headaches should be migraine.[1]

How to use this screener

The following questions can help you and your physician understand your condition and help determine if you may have Chronic Migraine. Being thorough about your headaches/migraines will help your physician determine how much your headaches affect your daily life, and help get you to a more accurate diagnosis and find treatment options that are right for you.[2]

Personal information

Name _____

Date of birth _____

Important information before you get started

What are headache days?

It's important to understand the number of days you had *headaches* (including migraines) rather than the number of *attacks*.[2]

- For example, you may have a headache that starts on Monday and doesn't go away until Wednesday; it may be 1 attack, but that's considered 3 *headache days*

Remember to provide your doctor with an accurate number of **ALL of the days you experience headache pain of any kind.**

Are migraine days the same as headache days?

Some of your headaches may be a type of headache known as a *migraine*. If you experience any combination of the following symptoms, your headache may be a migraine[3]:

- Constant, throbbing pain felt on 1 side of the head (but can be on both sides)
- Sensitivity to light and sound
- Nausea and/or vomiting
- Headaches that get worse with movement (you may want to lie down)

Whether your headache is a migraine or not, it still counts as a *headache day*.

What if the headache gets better or goes away after I take medicine?

You should also count days that you treated/resolved your headache/migraine with either over-the-counter medication like ibuprofen or prescription medication like sumatriptan. These days are still considered as days *with* headache.

Fill this out to see if you may have Chronic Migraine

1. A. How many days in the **past month** did you spend *with* headache/migraine? (Include **ALL days with any headache pain of any kind,** even those you didn't feel you needed to take any medication for or only took an over-the-counter medication.) _____ day(s)

B. How many days in the past month did you spend **without ANY headache pain** of any kind (headache-free days)? _____ day(s)

C. Now subtract B from 31 and enter that number: _____ day(s)

In A **or** C, did you enter 15 or more? ☐ Yes ☐ No ◄-

2. Did any of your headaches/migraines last more than 4 hours if you didn't treat them? ☐ Yes ☐ No ◄-

3. Have you ever been diagnosed as having chronic headaches (including chronic tension-type or chronic sinus headaches)? ☐ Yes ☐ No

4. Have you ever been diagnosed as having migraines? ☐ Yes ☐ No

5. Do your headaches/migraines **impact your daily life**? ☐ Yes ☐ No

Rate the impact of your headaches/migraines on your daily life:

1	2	3	4	5	6	7	8	9	10
Mild									**Severe**

How many days in the past month have your headaches/migraines severely affected your daily life? _____ day(s)

6. In the past month, did you take anything to treat your headaches/migraines? ☐ Yes ☐ No

If "yes", how many days in the past month did you take something to treat your headaches/migraines **(including over-the-counter drugs, prescription medication, and vitamins/herbal remedies)?** _____ day(s)

Please list what you took:

_____

_____

_____

☐ **CHECK HERE IF YOU ANSWERED "YES" TO BOTH 1 AND 2 AND AT LEAST ONE OF THE OTHER QUESTIONS. YOU MAY HAVE CHRONIC MIGRAINE.**

Review this screener with your doctor. Call and schedule an appointment with his/her office, if you don't already have one.

It's important to discuss with your doctor what you can do about your headaches/migraines, and to find treatment options that are right for you.

References: 1. Lipton RB. Chronic migraine, classification, differential diagnosis, and epidemiology. *Headache*. 2011;51(suppl 2):77S-83S. **2.** Buse DC, Lipton RB. Facilitating communication with patients for improved migraine outcomes. *Curr Pain Headache Rep*. 2008;12(3):230-236. **3.** Headache Classification Subcommittee of the International Headache Society. The International Classification of Headache Disorders: 2nd edition. *Cephalalgia*. 2004;24(suppl 1):9-160.

Patient Name: _____

(0 = No pain / 10 = Pain as bad as you can imagine)

PAIN LEVELS:

Current Pain Level: | Least Pain Level: | Worst Pain Level: | Pain Goal:

IS PATIENT TAKING:

Blood Thinners?

Who Manages Blood Thinners?

Supplements?

Antibiotics?

DOES PATIENT HAVE:

Allergy to Contrast Dye, Latex, or Shellfish?

Liver Problems? (Hep C)

Diabetes?

MEDICATIONS-

Please list ALL medications, including herbal and over-the-counter:

Drug	Dose	Prescribing Provider

ALLERGIES-

Drug/Item	Reaction

Patient Name: _____

REVIEW OF SYSTEMS-

Please mark all current or chronic conditions:

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise (out of sorts)
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss
- ☐ Other: _____

HEENT
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Nasal discharge
- ☐ Sinus pressure
- ☐ Sore throat
- ☐ Visual changes
- ☐ Other: _____

Respiratory
- ☐ Chronic cough
- ☐ Cough
- ☐ Known TB exposure
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other: _____

Cardiovascular
- ☐ Chest pain
- ☐ Claudication (leg cramping)
- ☐ Edema (swelling)
- ☐ Palpitations
- ☐ Other: _____

Gastrointestinal
- ☐ Abdominal pain
- ☐ Blood in stools
- ☐ Change in stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Other: _____

Genitourinary-FEMALE
- ☐ Dysuria (painful urination)
- ☐ Hematuria (bloody urine)
- ☐ Polyuria (excessive urination)
- ☐ Urinary frequency
- ☐ Urinary incontinence
- ☐ Urinary retention
- ☐ Other: _____

Reproductive-FEMALE
- ☐ Abnormal Pap
- ☐ Dysmenorrhea (painful periods)
- ☐ Dyspareunia (painful intercourse)
- ☐ Hot flashes
- ☐ Irregular menses
- ☐ Vaginal discharge
- ☐ Other: _____

Genitourinary-MALE
- ☐ Dribbling
- ☐ Dysuria (painful urination)
- ☐ Hematuria (bloody urine)
- ☐ Polyuria (excessive urination)
- ☐ Slow stream
- ☐ Urinary frequency
- ☐ Urinary incontinence
- ☐ Urinary retention
- ☐ Other: _____

Reproductive-MALE
- ☐ Erectile dysfunction
- ☐ Penile discharge
- ☐ Sexual dysfunction
- ☐ Other: _____

Integumentary
- ☐ Breast discharge
- ☐ Breast lump
- ☐ Brittle hair
- ☐ Brittle nails
- ☐ Hair loss
- ☐ Hirsutism (male pattern hair in women)
- ☐ Hives
- ☐ Pruritis (itching)
- ☐ Mole changes
- ☐ Rash
- ☐ Skin lesion
- ☐ Other: _____

Neurological
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Gait disturbance
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Tremors
- ☐ Other: _____

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Other: _____

Metabolic/Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Polydipsia (excessive thirst)
- ☐ Polyphagia (excessive hunger)
- ☐ Other: _____

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Neck pain
- ☐ Other: _____

Hematologic/Lymphatic
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Lymphadenopathy (enlarged lymph nodes)
- ☐ Other: _____

Immunologic
- ☐ Contact allergy
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Seasonal allergies
- ☐ Other: _____

Patient Name: _____

PREVIOUS SURGERIES-

Please be as specific as possible:

Surgery	Date	Location/Physician

MEDICAL HISTORY-

Please be as specific as possible:

Condition	Management	Treatment Outcome

FAMILY HISTORY-

- Is your mother living: □ Yes □ No
  If Yes, Age: _____ If No, Age at death: _____
  List all medical problems: _____

- Is your father living: □ Yes □ No
  If Yes, Age: _____ If No, Age at death: _____
  List all medical problems: _____

- Siblings:
  □ Brother □ Sister Living: □ Yes □ No
  If Yes, Age: _____ If No, Age at death: _____
  List all medical problems: _____

  □ Brother □ Sister Living: □ Yes □ No
  If Yes, Age: _____ If No, Age at death: _____
  List all medical problems: _____

  □ Brother □ Sister Living: □ Yes □ No
  If Yes, Age: _____ If No, Age at death: _____
  List all medical problems: _____

Patient Name: _____

SOCIAL-

- Have you had any recent social changes (marriage, divorce, employment, etc.): □ Yes □ No
  If Yes, describe: _____
- Are you married: □ Yes □ No
  If Yes, How Long: _____ Name of spouse: _____
- Is your spouse deceased: □ Yes □ No If Yes, When: _____ / _____ / _____
- Have you been divorced: □ Yes □ No If Yes, How many times: _____
- Are you currently employed: □ Yes □ No If Yes, How long: _____
  Occupation: _____
- Are you receiving disability: □ Yes □ No
- Is this pain being treated by a workers compensation claim: □ Yes □ No
- Have you taken any legal action in regards to your pain: □ Yes □ No
- Have you ever been abused: □ Yes □ No If Yes, □ Physical □ Sexual □ Emotional

HABITS-

- Do you smoke: □ Yes □ No □ Quit When: _____ / _____ / _____
  If Yes, Packs per day: _____ Years: _____
- Do you smoke a pipe: □ Yes □ No □ Quit When: _____ / _____ / _____
  If Yes, How much: _____ Years: _____
- Do you chew tobacco: □ Yes □ No □ Quit When: _____ / _____ / _____
  If Yes, How much: _____ Years: _____
- Do you drink alcohol: □ Yes □ No □ Quit When: _____ / _____ / _____
  If Yes, How much: _____ Years: _____
- Do you use illegal drugs: □ Yes □ No □ Quit When: _____ / _____ / _____
  If Yes, How much: _____ Years: _____
  What types: _____
- Do you consume caffeine: □ Yes □ No
  If Yes,
  - □ Coffee _____ cups/day
  - □ Tea _____ cups/day
  - □ Soda _____ cups/day
  - □ Energy Drinks _____ cups/day