



Welcome to Abington Neurological Associates!

Thank you for choosing us for your care. To ensure your appointment goes smoothly, follow these instructions:

Confirm your appointment.

To ensure timely access to care and better accommodate our patients, **all appointments must be confirmed at least 24 hours in advance**, or they will be **automatically cancelled** and offered to patients on our waitlist. You may confirm your appointment by responding to our reminder message or calling our office. This helps us provide the best possible care to every patient.

Call us at least one day in advance if you can't make it.

Should you need to cancel or reschedule your appointment, we ask that you contact us at least 24 hours in advance at 215-957-9250. *Failure to do so will result in a \$100 no-show fee.* This policy is in place to ensure that we can offer open appointments to patients on our waiting list.

Arrive half an hour early.

We ask that you **arrive 30 minutes prior** to your scheduled appointment, as this allows us time to update your records and prepare you for your visit. *Please note that if you arrive after this time, your appointment may be rescheduled.*

Come prepared.

Required for your first appointment:

- **Photo ID, insurance card(s), and prescription card (if applicable).**
- **Payment method.** We accept cash, check, Visa, Mastercard, Discover, and American Express. Copayments/coinsurance/deductible amounts are contractually required and must be paid at the time of the visit.
- **Relevant medical records (if applicable).** If you have imaging results on CD/DVD, drop the discs off at the x-ray file room in Abington Jefferson Hospital (Buerger Building, ground floor) prior to your visit.
- **Current list of medications and supplements.**
- **Referral (if applicable).** If your insurance requires an electronic referral, you must obtain it from your primary care physician **prior** to your appointment. Our group NPI number is 1154432227.

All enclosed forms must be fully completed prior to your appointment.

All forms in this packet must be filled out completely and returned to us by mail, by fax, or in person. If you arrive for your appointment without completed forms, your visit may be delayed or rescheduled. These forms are mailed out to all new patients and are also available at www.abingtonneurology.com.

We look forward to meeting you soon.

Sincerely,
Abington Neurological Associates

Directions to our office:

1151 Old York Road, Suite 200, Abington, PA 19001

Southbound on Route 611

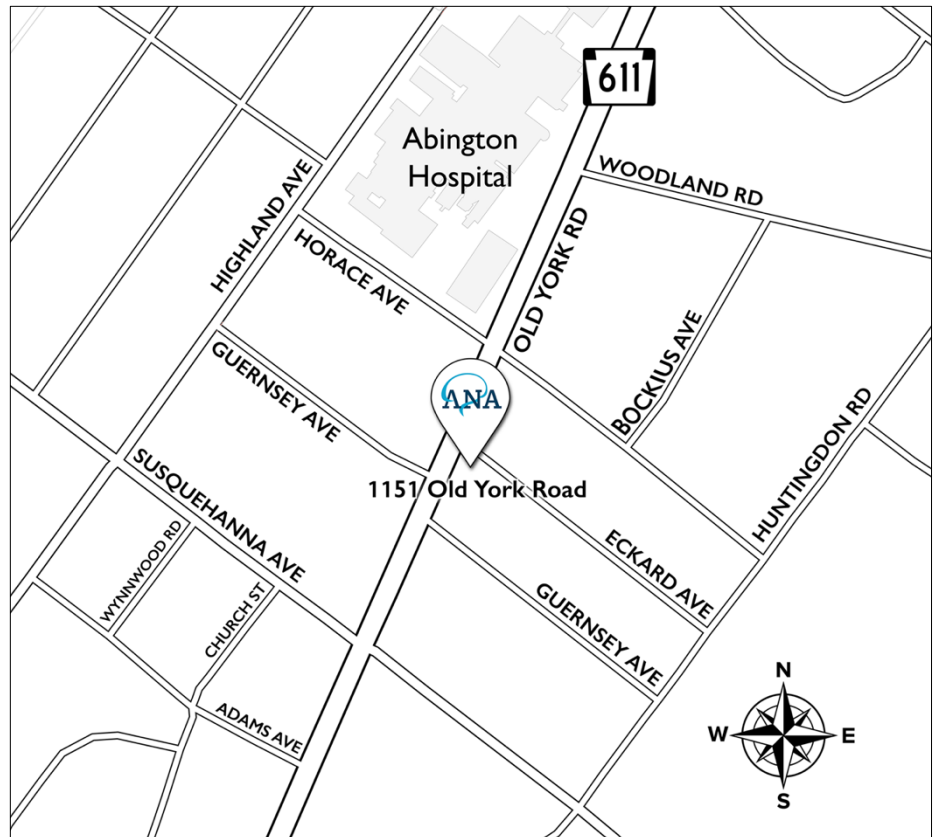
(Old York Road): After you pass Abington Hospital on your right, look for our office one block further south. Our office will be on your **left**.

Note: There is a left turn lane at Eckard Avenue that your GPS might not know about.

Northbound on Route 611

(Old York Road): After you pass Wells Fargo on your right, look for our office two blocks further north. Our office will be on your **right**.

Our office is on Old York Road, across from the magistrate's court and police station. The parking lot is accessible from the two side streets, Eckard Avenue and Guernsey Avenue.



When you enter our building, go up to the second floor.

Please allow extra time for travel. **We ask that you arrive at our office 30 minutes before your scheduled appointment time.**

Patient Information Sheet



Name: _____ DOB: _____ Gender: _____

Marital status: Married Single Widowed Divorced Spouse's name: _____

Social security*: _____ Email: _____

**Required for us to access your electronic medical records*

Home address: _____

List your phone numbers and check the number where we can leave voice messages.

Home: _____ Work: _____ Cell: _____

Tell us about your job. If you are retired and you get your insurance through your former employer, provide their information below.

Occupation: _____ Employer: _____

Address: _____

Who should we contact in case of an emergency?

Emergency contact: _____ Relationship to patient: _____

Phone: _____ Are we allowed to release health information to this person? Yes No

The responsible party is responsible for any unpaid balances:

Responsible party: _____ Relationship to patient: _____

Address: _____

Tell us about your primary health insurance. Call us if any of this information changes.

Primary insurance: _____ ID: _____

Address: _____ Phone: _____

Subscriber name: _____ Subscriber DOB: _____

Tell us about your secondary health insurance. Call us if any of this information changes.

Secondary insurance: _____ ID: _____

Address: _____ Phone: _____

Subscriber name: _____ Subscriber DOB: _____

Do you have a separate prescription card?

Prescription plan: _____ ID: _____

Do you have a Medical Power of Attorney? Yes No **Do you have a living will?** Yes No

If Yes, please bring a copy with you to your first appointment or fax it to us at 215-957-9254.

Patient name: _____

Which doctor referred you to us? (Leave blank if not applicable)

Referring physician: _____ Phone: _____

Address: _____

Who is your primary care physician?

Primary care physician: _____ Phone: _____

Address: _____

Write down any other physicians you see on a regular basis. We will send copies of our office notes to them and to your primary care physician unless we are instructed not to. If it's a long list, you can bring it on a separate piece of paper.

Physician: _____ Phone: _____

Address: _____

Physician: _____ Phone: _____

Address: _____

Physician: _____ Phone: _____

Address: _____

Physician: _____ Phone: _____

Address: _____

What local pharmacy do you use?

Local pharmacy: _____

Local pharmacy address: _____

Do you use a mail order pharmacy?

Mail order pharmacy: _____

Mail order pharmacy address: _____

Answer these questions if you are a Medicare patient.

Is Medicare your primary insurance? Yes No

Do you or your spouse work for a company that provides you with health insurance? Yes No

Are you entitled to Medicare because of disability or end-stage renal disease? Yes No

Are you entitled to any benefits under the Federal Black Lung Program? Yes No

Has the Department of Veterans Affairs authorized treatment for this illness? Yes No

New Patient History



Name: _____ Date of birth: _____ Today's date: _____

Age: _____ Height: _____ Weight: _____ Handedness: Left Right Ambidextrous

Occupation: _____ Marital status: Married Divorced Widowed Single

What types of testing/treatment have you tried? Write the names of the care providers (if known).

- | | |
|---|---|
| <input type="checkbox"/> Primary care provider: _____ | <input type="checkbox"/> Massage: _____ |
| <input type="checkbox"/> Neurologist: _____ | <input type="checkbox"/> Acupuncture/acupressure: _____ |
| <input type="checkbox"/> ENT/otolaryngologist: _____ | <input type="checkbox"/> Herbal/homeopathic: _____ |
| <input type="checkbox"/> Dentist/dental: _____ | <input type="checkbox"/> MRI scans: _____ |
| <input type="checkbox"/> Chiropractor: _____ | <input type="checkbox"/> CT scans: _____ |
| <input type="checkbox"/> Ophthalmologist: _____ | <input type="checkbox"/> Vascular studies: _____ |
| <input type="checkbox"/> Psychiatrist/psychologist: _____ | <input type="checkbox"/> Blood tests: _____ |
| <input type="checkbox"/> Biofeedback/relaxation: _____ | <input type="checkbox"/> Specialty: _____ |
| <input type="checkbox"/> Physical therapy: _____ | <input type="checkbox"/> Other: _____ |

General medical history

Describe when and how long you have experienced any of the following conditions:

- | | |
|---|---|
| <input type="checkbox"/> High blood pressure: _____ | <input type="checkbox"/> Anemia: _____ |
| <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> Bleeding: _____ |
| <input type="checkbox"/> Thyroid disease: _____ | <input type="checkbox"/> Ulcers: _____ |
| <input type="checkbox"/> Heart failure/CHF: _____ | <input type="checkbox"/> Arthritis: _____ |
| <input type="checkbox"/> Heart attack/MI: _____ | <input type="checkbox"/> HIV/AIDS: _____ |
| <input type="checkbox"/> Emphysema/COPD: _____ | <input type="checkbox"/> Lupus: _____ |
| <input type="checkbox"/> Pneumonia/TB: _____ | |

List any other major illnesses. Include the year of onset.

List any important previous injuries. Include the date of the incident.

List any important hospital visits or surgeries. Include the date, hospital, and reason for admission.

If you have any allergies, check the appropriate box and write your allergy/allergies in the space below.

- Drugs/meds X-ray dye Other _____

Patient name: _____

List your medications, including supplements, drops, sprays, birth control, over-the-counter meds, pain pills, etc. If you can't fit them all in the space below, write the list on a separate sheet of paper.

Name of medication	Dosage	# per day	Year started	Year stopped

Tell us about any tobacco use.

- Current smoker: How many cigarettes or packs do you smoke per day? _____
- Former smoker: For how many years? _____ Why did you quit? _____
- Never a smoker Light smoker Other tobacco products: _____

How many alcoholic drinks do you have during an average day?

Weekdays: Bottles/cans of beer: _____ Glasses of wine: _____ Shots of liquor: _____

Weekends: Bottles/cans of beer: _____ Glasses of wine: _____ Shots of liquor: _____

Do you consume significantly less alcohol now than you did in the past? Yes No

How many caffeinated drinks do you have during an average day?

Cups of coffee: _____ Cups of tea: _____ Bottles/cans of soda: _____

Write the age of each of your relatives. If they are deceased, write the letter D next to their age at death.

Mother: _____ Sisters: _____ Daughters: _____

Father: _____ Brothers: _____ Sons: _____

Check any conditions that your blood relatives have had.

Mother:	Father:	Sisters:	Brothers:	Daughters:	Sons:
<input type="checkbox"/> Headaches	<input type="checkbox"/> Headaches	<input type="checkbox"/> Headaches	<input type="checkbox"/> Headaches	<input type="checkbox"/> Headaches	<input type="checkbox"/> Headaches
<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stroke
<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Epilepsy/seizures
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Alzheimer's disease
<input type="checkbox"/> Brain tumor	<input type="checkbox"/> Brain tumor	<input type="checkbox"/> Brain tumor	<input type="checkbox"/> Brain tumor	<input type="checkbox"/> Brain tumor	<input type="checkbox"/> Brain tumor
<input type="checkbox"/> Other neurological	<input type="checkbox"/> Other neurological	<input type="checkbox"/> Other neurological	<input type="checkbox"/> Other neurological	<input type="checkbox"/> Other neurological	<input type="checkbox"/> Other neurological
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Lung disease	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Lung disease
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Psychiatric problems	<input type="checkbox"/> Psychiatric problems	<input type="checkbox"/> Psychiatric problems	<input type="checkbox"/> Psychiatric problems	<input type="checkbox"/> Psychiatric problems	<input type="checkbox"/> Psychiatric problems

Tell us anything else we should know about your family history. Are other diseases common in your family?

Patient name: _____

Quality of life review

Sleep

Hours of sleep per night: _____

Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> I have no trouble falling and staying asleep | <input type="checkbox"/> I am excessively sleepy during the day |
| <input type="checkbox"/> I have trouble falling asleep | <input type="checkbox"/> My legs jerk while sleeping |
| <input type="checkbox"/> I have trouble staying asleep | <input type="checkbox"/> I have restless legs |
| <input type="checkbox"/> I wake up for no apparent reason | <input type="checkbox"/> My headache awakens me |
| <input type="checkbox"/> I snore | <input type="checkbox"/> I wake up with headaches in the morning |
| <input type="checkbox"/> I stop breathing in my sleep | <input type="checkbox"/> I sleep too much |
| <input type="checkbox"/> I have sleep apnea | |

Sexual function

Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Normal | <input type="checkbox"/> No orgasms |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Problems with erections |
| <input type="checkbox"/> Increased libido | <input type="checkbox"/> Other: _____ |

Headache's effect on your ability to function in everyday life

Enter the **number of days missed per month** of work, school, and/or social and family activities.

- Work productivity: _____ days per month missed
- School productivity: _____ days per month missed
- Social/family activities: _____ days per month missed

Types of headache

The following pages contain detailed questions about your headache history and symptoms.

If you have **one** type of headache, fill in Headache Type 1 and skip Headache Type 2.

If you have **two** types of headache, fill in information for Headache Type 1 and Headache Type 2.

If you have **three or more** types of headache, photocopy or print out copies of the next three pages. You can get an electronic copy of this packet at abingtonneurology.com/download-forms.

Headache Type 1

Are you ever headache free? If so, when?

- Never Pregnancy Vacations Weekends Random times Other: _____

Onset of first headache

How old were you when your headaches started? _____

What provoked your first headache?

- Unknown Menarche Pregnancy Injury: _____ Other: _____

Premonitory symptoms

Do you experience any of these symptoms **before** the headache?

- | | | |
|---|---|--|
| <input type="checkbox"/> Heightened feeling of wellness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Increased appetite |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Decreased appetite |
| <input type="checkbox"/> Extremely talkative | <input type="checkbox"/> Sensitive to sounds | <input type="checkbox"/> Feeling cold |
| <input type="checkbox"/> Depressed feeling | <input type="checkbox"/> Sensitive to odors | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Difficulty with speech | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Feeling sluggish | <input type="checkbox"/> Excessive yawning | <input type="checkbox"/> Extreme thirst |
| <input type="checkbox"/> Drowsy | <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Increased urination |
| <input type="checkbox"/> Restless | <input type="checkbox"/> Food cravings | <input type="checkbox"/> Fluid retention |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Weakness | <input type="checkbox"/> Other: _____ |

Aura (visual)

Do you experience any of these symptoms **before** the headache?

- | | | |
|--|---|--|
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Loss of vision in one eye | <input type="checkbox"/> Tunnel vision |
| <input type="checkbox"/> Flashing lights | <input type="checkbox"/> Loss of vision on one side | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Zig zag lines | <input type="checkbox"/> Total blindness | <input type="checkbox"/> Other: _____ |

Do the symptoms spread? Yes, the symptoms spread slowly No, the symptoms begin all at once

When do visual symptoms start? Before the pain During the pain Both before and during pain

How long do the visual symptoms last? _____

How much time elapses between the visual symptoms and the headache? _____

Do you have visual auras without headache pain? Yes No

Aura (sensory)

Do you experience any of these symptoms **before** the headache?

- | | | |
|--|---|---|
| <input type="checkbox"/> Numbness/tingling — Right | <input type="checkbox"/> Room spinning | <input type="checkbox"/> Weakness — General |
| <input type="checkbox"/> Numbness/tingling — Left | <input type="checkbox"/> Lightheaded | <input type="checkbox"/> Speech difficulty |
| <input type="checkbox"/> Numbness/tingling — Both | <input type="checkbox"/> Weakness — Right | <input type="checkbox"/> Unable to speak |
| <input type="checkbox"/> Unsteadiness | <input type="checkbox"/> Weakness — Left | <input type="checkbox"/> Other: _____ |

When do sensory symptoms start? Before the pain During the pain Both before and during pain

How long do the sensory symptoms last? _____

How much time elapses between the sensory symptoms and the headache? _____

Do you have sensory auras without headache pain? Yes No

Headache Type 1

Escalation time

On average, how quickly do your headaches escalate to their most severe intensity?

- Within seconds Within 5 minutes Within hours Within days

Headache character

Check all that apply:

- | | | |
|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Throbbing/pulsating | <input type="checkbox"/> Shooting | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Achy | <input type="checkbox"/> Tight |
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Burning | <input type="checkbox"/> Other: _____ |

Location

Sidedness: Right-sided Left-sided Both sides Varies

Does it change sides? No Between attacks During attacks Both between and during

Check all that apply:

- | | | |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Front of head | <input type="checkbox"/> Eye | <input type="checkbox"/> Back of head |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Side of head | <input type="checkbox"/> Jaw |
| <input type="checkbox"/> Temples | <input type="checkbox"/> Neck | <input type="checkbox"/> Around head |
| <input type="checkbox"/> Other: _____ | | |

Associated symptoms during headache

- | | | |
|---|---|---|
| <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Confusion | <input type="checkbox"/> Increased urination |
| <input type="checkbox"/> Sensitive to sound | <input type="checkbox"/> Memory issues | <input type="checkbox"/> Eye tearing:
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Sensitive to odors | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Nose congestion:
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Eye redness:
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Drooping eyelid:
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hearing pulsations in the ears | <input type="checkbox"/> Change in pupil:
<input type="checkbox"/> Larger <input type="checkbox"/> Smaller |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Room spinning | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Feeling as if you are swaying
on a boat | |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Numbness
<i>Where?</i> _____ | |
| <input type="checkbox"/> Sore/stiff neck | <input type="checkbox"/> Weakness
<i>Where?</i> _____ | |
| <input type="checkbox"/> Lightheaded | | |
| <input type="checkbox"/> Anxiety | | |
| <input type="checkbox"/> Irritability | | |

Activities that worsen headache

- | | | |
|-----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Movement in general | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Climbing | <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ |

Sleep

Do the headaches awaken you from sleep? Yes No

Do you awaken with the headache in the morning? Yes No

Do you awaken with headache after naps? Yes No Not applicable

Headache Type 1

Provoking factors

What brings on a headache? Check all that apply.

- Food/beverage:** Fasting Chocolate Caffeine Nitrates MSG
 Alcoholic beverages Red wine White wine Other: _____
- Physical exertion:** Coughing Talking Chewing Exercise Sexual intercourse
- Hormonal:** Before menses During menses After menses
 Pregnancy Menopause
- Stress:** Work Home Family Spouse Other: _____
- Environmental:** Temperature changes Barometric pressure changes
 Allergies Altitude Sunlight Other: _____
- Sleep:** Lack of sleep Too much sleep Change in wake/sleep

Other triggers: _____

Relieving factors

- Lying down Hot compress Massage
 Dark quiet room Cold compress Pregnancy
 Keeping active/pacing Standing Other: _____

Headache frequency

Enter the number of attacks:

_____ per day _____ per week _____ per month _____ per year Continuous

If you have continuous headache, how often do your headaches become more severe and/or debilitating?

_____ per day _____ per week _____ per month _____ per year Continuous N/A

When are your headaches more frequent?

Spring Summer Fall Winter Weekends Weekdays Vacation N/A

Headache severity

Rate the pain on a scale from 0 to 10, where 0 is no pain and 10 is the worst.

Range of severity of pain for this headache type: Lowest: _____ Highest: _____

Average severity of pain for this headache type: _____

Is it worse with menses? Yes No

Headache disability (decrease in function) during or after an attack

- Normal activity Moderate decrease in function Confined to bed
 Slight decrease in function Severe decrease in function

Headache duration

How long do they last? Estimate the amount of time in minutes/hours/days.

With medication: _____ % of time they recur within 24 hrs: _____

Without medication: _____ % of time they recur within 24 hrs: _____

If you only have one headache type, skip the next 3 pages.

Headache Type 2

Are you ever headache free? If so, when?

- Never Pregnancy Vacations Weekends Random times Other: _____

Onset of first headache

How old were you when your headaches started? _____

What provoked your first headache?

- Unknown Menarche Pregnancy Injury: _____ Other: _____

Premonitory symptoms

Do you experience any of these symptoms **before** the headache?

- | | | |
|---|---|--|
| <input type="checkbox"/> Heightened feeling of wellness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Increased appetite |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Decreased appetite |
| <input type="checkbox"/> Extremely talkative | <input type="checkbox"/> Sensitive to sounds | <input type="checkbox"/> Feeling cold |
| <input type="checkbox"/> Depressed feeling | <input type="checkbox"/> Sensitive to odors | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Difficulty with speech | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Feeling sluggish | <input type="checkbox"/> Excessive yawning | <input type="checkbox"/> Extreme thirst |
| <input type="checkbox"/> Drowsy | <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Increased urination |
| <input type="checkbox"/> Restless | <input type="checkbox"/> Food cravings | <input type="checkbox"/> Fluid retention |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Weakness | <input type="checkbox"/> Other: _____ |

Aura (visual)

Do you experience any of these symptoms **before** the headache?

- | | | |
|--|---|--|
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Loss of vision in one eye | <input type="checkbox"/> Tunnel vision |
| <input type="checkbox"/> Flashing lights | <input type="checkbox"/> Loss of vision on one side | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Zig zag lines | <input type="checkbox"/> Total blindness | <input type="checkbox"/> Other: _____ |

Do the symptoms spread? Yes, the symptoms spread slowly No, the symptoms begin all at once

When do visual symptoms start? Before the pain During the pain Both before and during pain

How long do the visual symptoms last? _____

How much time elapses between the visual symptoms and the headache? _____

Do you have visual auras without headache pain? Yes No

Aura (sensory)

Do you experience any of these symptoms **before** the headache?

- | | | |
|--|---|---|
| <input type="checkbox"/> Numbness/tingling — Right | <input type="checkbox"/> Room spinning | <input type="checkbox"/> Weakness — General |
| <input type="checkbox"/> Numbness/tingling — Left | <input type="checkbox"/> Lightheaded | <input type="checkbox"/> Speech difficulty |
| <input type="checkbox"/> Numbness/tingling — Both | <input type="checkbox"/> Weakness — Right | <input type="checkbox"/> Unable to speak |
| <input type="checkbox"/> Unsteadiness | <input type="checkbox"/> Weakness — Left | <input type="checkbox"/> Other: _____ |

When do sensory symptoms start? Before the pain During the pain Both before and during pain

How long do the sensory symptoms last? _____

How much time elapses between the sensory symptoms and the headache? _____

Do you have sensory auras without headache pain? Yes No

Headache Type 2

Escalation time

On average, how quickly do your headaches escalate to their most severe intensity?

- Within seconds Within 5 minutes Within hours Within days

Headache character

Check all that apply:

- | | | |
|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Throbbing/pulsating | <input type="checkbox"/> Shooting | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Achy | <input type="checkbox"/> Tight |
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Burning | <input type="checkbox"/> Other: _____ |

Location

Sidedness: Right-sided Left-sided Both sides Varies

Does it change sides? No Between attacks During attacks Both between and during

Check all that apply:

- | | | |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Front of head | <input type="checkbox"/> Eye | <input type="checkbox"/> Back of head |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Side of head | <input type="checkbox"/> Jaw |
| <input type="checkbox"/> Temples | <input type="checkbox"/> Neck | <input type="checkbox"/> Around head |
| <input type="checkbox"/> Other: _____ | | |

Associated symptoms during headache

- | | | |
|---|---|---|
| <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Confusion | <input type="checkbox"/> Increased urination |
| <input type="checkbox"/> Sensitive to sound | <input type="checkbox"/> Memory issues | <input type="checkbox"/> Eye tearing:
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Sensitive to odors | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Nose congestion:
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Eye redness:
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Drooping eyelid:
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hearing pulsations in the ears | <input type="checkbox"/> Change in pupil:
<input type="checkbox"/> Larger <input type="checkbox"/> Smaller |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Room spinning | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Feeling as if you are swaying
on a boat | |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Numbness
<i>Where?</i> _____ | |
| <input type="checkbox"/> Sore/stiff neck | <input type="checkbox"/> Weakness
<i>Where?</i> _____ | |
| <input type="checkbox"/> Lightheaded | | |
| <input type="checkbox"/> Anxiety | | |
| <input type="checkbox"/> Irritability | | |

Activities that worsen headache

- | | | |
|-----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Movement in general | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Climbing | <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ |

Sleep

Do the headaches awaken you from sleep? Yes No

Do you awaken with the headache in the morning? Yes No

Do you awaken with headache after naps? Yes No Not applicable

Headache Type 2

Provoking factors

What brings on a headache? Check all that apply.

- Food/beverage:** Fasting Chocolate Caffeine Nitrates MSG
 Alcoholic beverages Red wine White wine Other: _____
- Physical exertion:** Coughing Talking Chewing Exercise Sexual intercourse
- Hormonal:** Before menses During menses After menses
 Pregnancy Menopause
- Stress:** Work Home Family Spouse Other: _____
- Environmental:** Temperature changes Barometric pressure changes
 Allergies Altitude Sunlight Other: _____
- Sleep:** Lack of sleep Too much sleep Change in wake/sleep
- Other triggers:** _____

Relieving factors

- Lying down Hot compress Massage
 Dark quiet room Cold compress Pregnancy
 Keeping active/pacing Standing Other: _____

Headache frequency

Enter the number of attacks:

_____ per day _____ per week _____ per month _____ per year Continuous

If you have continuous headache, how often do your headaches become more severe and/or debilitating?

_____ per day _____ per week _____ per month _____ per year Continuous N/A

When are your headaches more frequent?

Spring Summer Fall Winter Weekends Weekdays Vacation N/A

Headache severity

Rate the pain on a scale from 0 to 10, where 0 is no pain and 10 is the worst.

Range of severity of pain for this headache type: Lowest: _____ Highest: _____

Average severity of pain for this headache type: _____

Is it worse with menses? Yes No

Headache disability (decrease in function) during or after an attack

- Normal activity Moderate decrease in function Confined to bed
 Slight decrease in function Severe decrease in function

Headache duration

How long do they last? Estimate the amount of time in minutes/hours/days.

With medication: _____ % of time they recur within 24 hrs: _____

Without medication: _____ % of time they recur within 24 hrs: _____

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Patient name: _____

Failed Headache Medications – Preventive

Indicate any drugs used daily for headache **prevention**. Where possible, provide the following information:

- **Dose:** Highest dose used (note whether it was divided throughout the day)
- **Time:** Length of time the medication was used, measured in weeks or months
- **NE:** Indicate if the medication was **not effective** (“NE”)
- **Side effects:** List any problems you had with the medication

Medication	Dose	Time	NE?	Side effects?	Medication	Dose	Time	NE?	Side effects?
ACE inhibitor					Monoclonal antibodies				
lisinopril					Aimovig (erenumab)				
AED					Ajoovy (fremanezumab)				
Banzel (rufinamide)					Emgality (galcanezumab)				
Depakote (valproic Acid)					Ubrovelvy (ubrogepant)				
Dilantin (phenytoin)					Vyepti (eptinezumab)				
Gabitril (tiagabine)					Muscle relaxants				
Keppra (levetiracetam)					Baclofen				
Lamictal (lamotrigine)					Flexeril (cyclobenzaprine)				
Lyrica (pregabalin)					Lorzone (chlorzoxazone)				
Neurontin (gabapentin)					Parafon Forte (chlorzoxazone)				
Tegretol (carbamazepine)					Skelaxin (metaxalone)				
Topamax (topiramate)					Soma (carisoprodol)				
Trileptal (oxcarbamazepine)					Zanaflex (tizanadine)				
Vimpat (lacosamide)					NDRI				
ARB					Wellbutrin (bupropion)				
Candesartan					Zyban (bupropion)				
Benzodiazepines					Neuroleptics				
Ativan (lorazepam)					Abilify (aripiprazole)				
Klonopin (clonazepam)					Haldol (haloperidol)				
Librium (chlordiazepoxide)					Navane (thiothixene)				
Limbitrol (chlordiazepoxide)					Risperdal (risperdone)				
Valium (diazepam)					Seroquel (quetiapine)				
Xanax (alprazolam)					Triavil (phenothiazine)				
Beta blockers					Thorazine (chlorpromazine)				
Corgard (nadolol)					Zyprexa (olanzapine)				
Inderal (propranolol)					NSAID				
Tenormin (atenolol)					Arthrotec (diclofenac & misoprostol)				
Timolol					Cataflam (diclofenac)				
Toprol (metoprolol)					Clinoril (sulindac)				
Calcium channel blocker					Feldene (piroxicam)				
Calan (verapamil)					Indocin (indomethacin)				
Cardizem (diltiazem)					Mobic (meloxicam)				
Norvasc (amlodipine)					Relafen (nabumetone)				
Plendil (felodipine)					Voltaren (diclofenac)				
Procardia (nifedipine)					SNRI				
MAOI					Cymbalta (duloxetine)				
Nardil (phenelzine)					Effexor XR (venlafaxine)				
Parnate (tranylcypromine)					Savella (milnacipran)				

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Patient name: _____

Failed Headache Medications – Preventive (continued)

Medication	Dose	Time	NE?	Side effects?	Medication	Dose	Time	NE?	Side effects?
Miscellaneous					SSRI				
Catapres (clonidine)					Buspar (buspirone)				
Coenzyme Q10					Celexa (citalopram)				
Desyrel (Trazodone)					Lexapro (escitalopram)				
Diamox (acetazolamide)					Luvox (fluvoxamine)				
Feverfew					Paxil (paroxetine)				
Lithium					Prozac (fluoxetine)				
Magnesium					Zoloft (sertraline)				
Melatonin					TCA				
Methergine (methylergometrine)					Elavil (amitriptyline)				
Migrelief (Mg, B12, feverfew)					Norpramin (desipramine)				
Periactin (cyproheptadine)					Pamelor (nortriptyline)				
Petadolex					Sinequan (doxepin)				
Remeron (mirtazapine)					Tofranil (imipramine)				
Sansert (methysergide)					Vivactil (protryptaline)				
Serzone (nefazodone)					Procedures				
Vitamin B2 (riboflavin)					Botox (botulinum toxin)				

Failed Headache Medications – Rescue/Abortive

Indicate any medicines that you have taken as a headache **rescue/abortive**. Where possible, provide:

- **Dose:** Highest dose used (note whether it was divided throughout the day)
- **NE:** Indicate if the medication was **not effective** (“NE”)
- **Side effects:** List any problems you had with the medication

Medication	Dose	Time	NE?	Side effects?	Medication	Dose	Time	NE?	Side effects?
Anti-inflammatory					Barbiturates				
Advil, Motrin (ibuprofen)					Fioricet (butalbital, acetaminophen, caffeine)				
Aleve, Anaprox, Naprelan (naprosyn)					Fioricet with codeine				
Arthrotec (diclofenac, misoprostol)					Fiorinal (butalbital, aspirin, caffeine)				
Aspirin					Fiorinal with codeine				
Cambia (diclofenac)					Phrenilin (butalbital & acetaminophen)				
Celebrex (celecoxib)					Nembutal (pentobarbital)				
Clinoril (sulindac)					Benzodiazepines				
Daypro (oxaprozin)					Klonopin (clonazepam)				
Excedrin					Valium (diazepam)				
Feldene (piroxicam)					Xanax (alprazolam)				
Indocin (indomethacin)					Combinations				
Orudis, Oruvail (ketoprofen)					Bellergal (belladonna, ergotamine, & phenobarbital)				
Relafen (nabumetone)					Cafergot (ergotamine & caffeine)				
Toradol (ketorolac)									
Vioxx									
Voltaren (diclofenac)									

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Authorization for Release of Medical Records



Patient name: _____ Date of birth: _____

Patient instructions: To obtain medical records from other healthcare providers, we might need your signed authorization for them to share records with us. Please sign below to grant permission.

We also need to know if you would allow us to disclose any health information related to mental health, substance abuse, and HIV/AIDS. Even if these do not apply to you right now, we need to know what to do if they become relevant in the future.

Patient authorization

I authorize the release of records pertinent to my care at Abington Neurological Associates.

This includes specific instructions to release or withhold the following sensitive information:

- | | | |
|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Release | <input type="checkbox"/> Withhold | Psychological, psychiatric, or other mental impairments
(excludes "psychotherapy notes" as defined in 45 CFR 164.501) |
| <input type="checkbox"/> Release | <input type="checkbox"/> Withhold | Drug abuse, alcoholism, or other substance abuse |
| <input type="checkbox"/> Release | <input type="checkbox"/> Withhold | Human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or tests for HIV or sexually transmitted diseases |

Patient signature: _____ Date signed: _____

For office use only

Requesting provider:

- | | | |
|---|---|--|
| <input type="checkbox"/> James H. Cook, MD | <input type="checkbox"/> Minsoo Kim, MD | <input type="checkbox"/> David C. Weisman, MD |
| <input type="checkbox"/> Steven D. Factor, MD | <input type="checkbox"/> Brad C. Klein, MD | <input type="checkbox"/> Sarah S. Smith, CRNP |
| <input type="checkbox"/> Dan J. Gzesh, MD | <input type="checkbox"/> Kandan Kulandaivel, MD | <input type="checkbox"/> Karen Chen, PA-C |
| <input type="checkbox"/> Lee J. Harris, MD | <input type="checkbox"/> Diana Z. Li, MD | <input type="checkbox"/> Rinsu S. Varghese, CRNP |
| <input type="checkbox"/> John S. Khoury, MD | <input type="checkbox"/> Kartik Sivaraaman, MD | |

For the purposes of neurological treatment, please release the following information to Abington Neurological Associates. You may fax the records specified below to **215-957-9254** or mail them to **1151 Old York Road, Suite 200, Abington, PA 19001**. If you have any questions, call **215-957-9250**.

- Office visit notes
- Hospital visit records
- Diagnostic tests (e.g., MRI, radiology, electrodiagnostics)
- Laboratory reports (e.g., blood tests, biopsy, cytology)
- Other:

Consent for General Care and Treatment



As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure(s) to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. By providing your email address you authorize us to send you medical information, medical events, or information on services you may be eligible for. You may opt out at any time. We do not sell or share email addresses with any third party.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or physician assistant, or their designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended; I will be asked to read and sign additional consent forms prior to the tests(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient name: _____

Date of birth: _____

Signature: _____

Today's date: _____

Patient or authorized representative

Authorized representative information, if applicable:

Name: _____

Relationship to patient: _____

(Spouse, caregiver, etc.)

Financial Disclosure



We, the staff of Abington Neurological Associates, Ltd. thank you for choosing us as your healthcare provider. We believe that it is important for our patients to understand their financial responsibility. Please read the following information and sign below acknowledging your understanding. Thank you.

We accept cash, check, Visa, MasterCard, Discover, and American Express. Our office collects all expected patient responsibility amounts prior to service. A \$35.00 service fee will be charged for all returned checks.

Please remember that your insurance policy is a contract between you and your insurance carrier. We will gladly submit the claim to your insurance carrier on your behalf for insurances that we are in network. Please note that any copays, deductibles or non-covered services are your responsibility and will be collected on the day of your appointment. If a referral is required, and is not obtained prior to your appointment, we reserve the right to reschedule your appointment, or bill you for services rendered. If you choose to be seen at our practice, outside of your insurance network/coverage, you will be solely responsible for all fees. In addition, if you require testing or medication that requires preauthorization, our office will not be able to obtain this for you due to our non-participation with your plan.

Any non-covered services such as injections of any kind, including Botox, Occipital, Nerve Blocks of any type, or infusions will be the responsibility of the patient. All balances for these services are due immediately.

Starting 6/1/2023, Physician, PA and NP phone calls for medical advice that last over 5 minutes that are not within 7 days of a visit and do not result in an emergency appointment or ER visit, are considered billable encounters under the CPT codes G2012. The Medicare payment for this code is \$15.42. Your insurance provider may vary from these rates. Please check with your insurance company what your out of pocket expenses may be for these new services.

Forms: Effective October 1, 2019, physicians may fill out appropriate forms (i.e. disability, FMLA, life insurance, etc.) for a \$20 service fee for the first page plus \$5 per additional page. Forms are to be given to the receptionist at the front desk when you check in. Do not give forms to the provider during the appointment. All forms must go through the Medical Records Department first - **no exceptions**. If you mail or fax a form to us, we cannot fill it out if it has been more than 30 days since your last appointment. Exceptions are made on a case-by-case basis. Please allow **at least 5-10 business days** for us to complete the forms.

Missed Appointments: We require notice of cancellation 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointment without notifying us in advance or are late for your appointment, a no-show fee will apply. **This fee is \$100.00 for new patients and \$75.00 for follow-ups. Repeated missed appointments without notification, or frequent cancellations, may result in being discharged from the practice so that we can provide care to other patients.**

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Payment contracts are not available on elective services such as injections or infusions. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification.

I have read and understand the above financial policy.

Patient name: _____ **Date of birth:** _____

Signature: _____ **Today's date:** _____
Patient or authorized representative

Witness: _____