Neurology Headache and Pain Clinic
Sachin R. Shenoy, M.D.
Board Certified in Neurology and Pain Management

Patient name _____ Date of birth _____ Male____ Female_____

Social security # _____ Home phone _____ Work phone _____

Cell Phone _____ Best Phone # to call (please circle) Home Cell Work

Referred By (Please List): Physician _____ Friend_____ Family _____

Heard about us from _____ Newspaper ____ Yellow Pages _____Radio _____ Internet _____

Mailing address _____ City_____

State _____ Zip _____

Have you ever seen Dr. Shenoy prior to today for any medical reason? Yes / No

Employer _____

Local person to contact in case of emergency _____ Phone # _____

Primary Insurance _____ Card Holders Name _____

Secondary Insurance _____ Card Holders Name _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) (ALL PATIENTS MUST SIGN)

I acknowledge that I have been given the opportunity to read the Heath Insurance Portability and Accountability Act of 1996 (HIPAA), and I agree to the terms set forth. Please Note: If your copy is missing there is a copy on the wall to the left of the check in window.

X_____

Signature of patient or parent if minor Date

AUTHORIZATION FOR US TO BILL MEDICARE FOR YOUR VISITS

I authorize payment of Medicare benefits to Sachin R. Shenoy MD, PA I authorize the release/transmission of pertinent medical information necessary to determine benefits. I realize that I am responsible for deductibles, co-payments, and non-covered expenses.

X _____

Signature of patient or parent if minor Date

AUTHORIZATION FOR US TO BILL YOUR COMMERCIAL OR SECONDARY INSURANCE FOR YOUR VISITS

I authorize payment of insurance benefits directly to Sachin R. Shenoy MD, PA and the release/transmission of pertinent medical information necessary to determine benefits. I am responsible for all charges not covered by insurance contracts, including co-payments, deductibles, non-covered services, and those determined by the insurance company to be above their usual and customary charges.

X _____

Signature of patient or parent if minor Date

Patient name_____ Date_____

PLEASE DESCRIBE YOUR PROBLEM IN A FEW WORDS:

_____

_____

_____

PAST MEDICAL HISTORY

Heart Disease	No	Yes	High Blood Pressure	No	Yes
Diabetes	No	Yes	Arthritis	No	Yes
Migraines	No	Yes	Thyroid Disease	No	Yes
High Cholesterol	No	Yes	TIA/ "mini stroke"	No	Yes
Heart Attack	No	Yes	Depression	No	Yes
Epilepsy	No	Yes	Stroke	No	Yes
Cancer	No	Yes	If yes, please name type of Cancer _____		
Any other Diseases	No	Yes	Please List_____		

PAST SURGICAL HISTORY

NO PRIOR SURGERIES ____ (Please proceed to next paragraph)

Tonsillectomy	No	Yes	Appendix removal	No	Yes
Gallbladder removal	No	Yes	Heart Bypass	No	Yes
Heart Stents	No	Yes	Leg Stents	No	Yes
Hip replacement	No	Yes	Knee replacement	No	Yes
Cancer Surgery	No	Yes	Pacemaker	No	Yes
For Female patients		Hysterectomy	No Yes		
		Ovaries removed	No Yes		
Brain Surgery	No	Yes	If yes, date(s)_____Type of surgery done _____		
Back Surgery	No	Yes	If yes, date(s)_____ Type of surgery done _____		
Neck Surgery	No	Yes	If yes, date(s)_____ Type of surgery done _____		

Please list any additional surgeries and date_____

PERSONAL HISTORY

Marital Status: Single _____ Married _____ Divorced _____Widowed

Alcohol: Do You Drink Alcohol Never _____ Yes _____ Quit _____ Current _____
If In the past when did you stop, what and how much did you consume _____

Tobacco: Do You use tobacco Never _____ Yes _____ Quit _____ Current _____
If In the past when did you stop, what and how much did you consume _____

Illegal Drugs Do You use illegal drugs Never _____ Yes _____ Quit _____ Current _____
If In the past when did you stop, what and how much did you consume _____

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FAMILY HISTORY

Father: □ Alive □ Deceased Major Illnesses _____
Mother □ Alive □ Deceased Major Illnesses _____
Brothers _____
Sisters _____
Children _____

Medications and dosage: (Please list all medications, dosages, and indicate how often you take the medication.)

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

Please List any allergies that you have

1._____

2._____

3._____

4._____

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Please indicate any if you have had any of the symptoms mentioned below in the last three months by circling the yes response. If you have not had the symptom listed below please do not circle.

□ General Symptoms

Recent weight change	Yes
Fever	Yes
Fatigue	Yes
Headaches	Yes

□ Eyes

Eye disease	Yes
Injury to eyes	Yes
Blurred or double vision	Yes

□ Ears/Nose/Mouth/Throat

Hearing loss	Yes
Earaches	Yes
Chronic sinus problem	Yes
Nose bleeds	Yes
Mouth sores	Yes
Bleeding gums	Yes
Sore throat or voice change	Yes

□ Heart related

Chest pain	Yes
Palpitation	Yes
Shortness of breath	Yes
Swelling of feet or ankles	Yes
Swelling of hands	Yes

□ Lung related

Chronic cough	Yes
Spitting up blood	Yes
Shortness of breath	Yes
Wheezing	Yes

□ Stomach related

Loss of appetite	Yes
Nausea	Yes
Vomiting	Yes
Frequent diarrhea	Yes
Painful bowel movements	Yes
Constipation	Yes
Rectal bleeding	Yes
Blood in stool	Yes

□ Urination and Sexual symptoms

Frequent urination	Yes
Painful urination	Yes
Blood in urine	Yes
Incontinence	Yes
Dribbling	Yes
Kidney stones	Yes
Sexual difficulty	Yes
Male – testicle pain	Yes
Female – pain with periods	Yes
Female – irregular periods	Yes
Female – vaginal discharge	Yes
Female - # of pregnancies ____	

□ Muscle and joint related

Knee pain	Yes
Hip pain	Yes
Joint stiffness	Yes
Muscle pain or Muscle cramps	Yes
Back pain	Yes

□ Skin and Breast

Rash or itching	Yes
Change in skin color	Yes
Change in hair or nails	Yes
Varicose veins	Yes
Breast pain	Yes
Breast lump	Yes
Breast discharge	Yes

□ Nervous system symptoms

Frequent recurring Headaches	Yes
Light headedness	Yes
Dizziness	Yes
Convulsions or seizures	Yes
Numbness or tingling Sensations	Yes
Tremors	Yes
Paralysis	Yes
Head injury	Yes

□ Psychiatric

Memory loss	Yes
Confusion	Yes
Nervousness	Yes
Depression	Yes
Insomnia	Yes
Suicidal thoughts	Yes
Violent thoughts	Yes

□ Hormone related

Excessive thirst	Yes
Heat intolerance	Yes
Cold intolerance	Yes
Skin becoming drier	Yes
Change in hat or glove size	Yes
Thyroid problem	Yes

□ Blood related

Slow to heal after cuts	Yes
Bleeding or bruising tendency	Yes
Anemia	Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need. I authorize Dr Shenoy and his staff to release to a physician/s of my choosing and to discuss my care with him/ her / them as needed. I also give Dr Shenoy permission to discuss my health issues with my prior treating physicians if needed. . I also authorize Dr Shenoy and or members of his staff to discuss my information as required by law with any law enforcement agency or other enforcement agencies if required by law.

_____ _____

Signature of Patient or Parent or Legal Guardian **Date**

Sachin R. Shenoy, M.D.
Neurology, Headache, and Pain Management Clinic
1845 Jess Parrish Ct, Titusville, Fl 32796
Phone (321) 264-2011 Fax (321) 264-0442

Authorization To Release Medical Records

I, _____, do hereby consent and authorize Dr. Sachin Shenoy to disclose to _____ information from my medical records relating to identity, diagnosis, prognosis, or treatment, including psychiatric disorders and substance abuse, results of HIV testing, diagnosis of Acquired Immune Deficiency Syndrome and diagnoses related to AIDS. I understand that the specific type of information to be released includes: medical records, x-ray reports, laboratory reports, admissions, consults, operative notes, and discharge summaries, and that the purpose or need for this disclosure is to continue medical care and/or provide information to the other parties as named above at my request.

_____ _____

Signature of patient, legal guardian, or Authorized representative

Date

_____ _____

Social Security Number

Date of Birth

Phone _____ - _____ - _____

Fax _____ - _____ - _____

Attention _____

Sachin R. Shenoy, M.D.
Neurology, Headache, and Pain Management Clinic
1845 Jess Parrish Ct, Titusville, Fl 32796
Phone (321) 264-2011 Fax (321) 264-0442

Patient Request and Authorization To Release Medical Records

I, _____, do hereby consent and authorize

_____ to disclose to Dr. Sachin Shenoy

information from my medical records relating to identity, diagnosis, prognosis, or treatment, including psychiatric disorders and substance abuse, results of HIV testing, diagnosis of Acquired Immune Deficiency Syndrome and diagnoses related to AIDS. I understand that the specific type of information to be released includes: medical records, x-ray reports, laboratory reports, admissions, consults, operative notes, and discharge summaries, and that the purpose or need for this disclosure is to continue medical care and/or provide information to the other parties as named above at my request.

_____ _____

Signature of patient, legal guardian, or Authorized representative

Date

_____ _____

Social Security Number

Date of Birth

Phone _____ - _____ - _____

Fax _____ - _____ - _____

Attention _____

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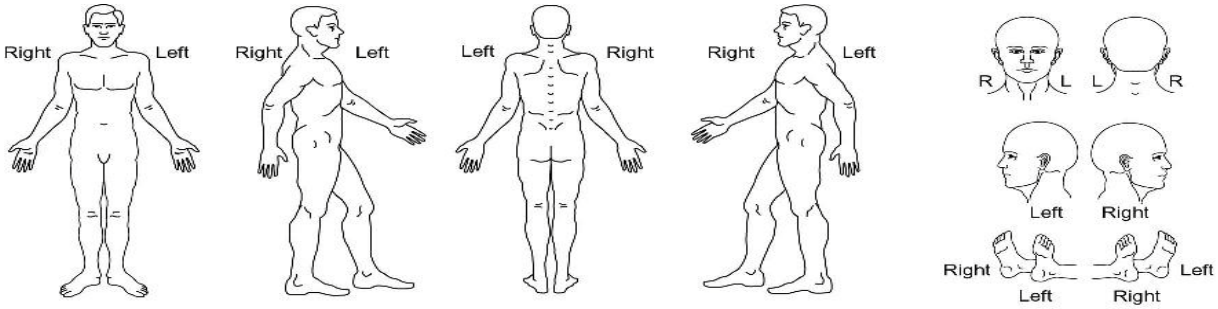
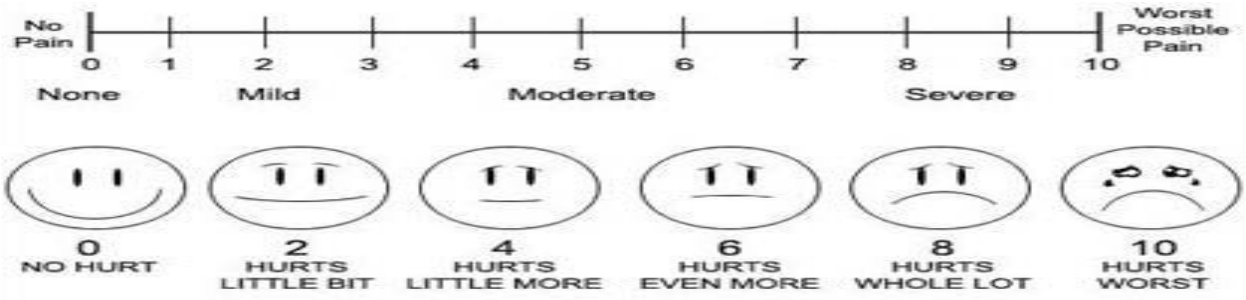
Pain Assessment Form

Patient's Name _____ **Date**_____

Please localize your pain on the diagram below



Please rate your pain below:



Type of pain: (Check up to eight)

__Cutting	__Throbbing	__Shooting	__Stabbing	__Sharp	__Cramping
__Gnawing	__Burning	__Aching	__Heavy	__Tender	__Splitting
__Exhausting	__Pulsing	__Stinging	__Dull	__Pulling	__Nauseating
__Radiating	__Wrenching	__Annoying	__Unbearable	__Tingling	__Pinching

What makes your pain worse?

_____

What makes your pain better?

_____

Current medications taken for pain?

_____

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Patient Name: _____ Date:_____

If you have been on or tried any of the medications below, please circle. If a medication has worked for you in the past please indicate so it can possibly be tried again. Please also list side effects next to the medication if any are known.

Anti-Depressants
Amitriptyline (Elavil)
Clomipramine (Anafranil)
Bupropion (Wellbutrin)
Nortriptyline (Pamelor)
Desipramine (Norpramin)
Doxepin (Sinequan)
Impramine (Tofranil)

SNRI's
Duloxetine (Cymbalta)
Trazodone (Deryrel)
Venlafaxine (Effexor)
Milnacipran (Savella)
Nefazodone (Serzone)
Desvenlafaxine (Pristiq)

Non-Narcotic Analgesics
Acetaminophen (Tylenol)
Aspirin
Butalbital (Esgic, Fiorinal)
Midrin (Isometheptene)
Tramadol (Ultram)
Lyrica

Muscle Relaxants
Carisoprodil (Soma)
Cyclobenzaprine (Flexeril)
Metazalone (Skelaxin)
Methocaramol (Robaxin)
Tizanidine (Zanaflex)

Multiple Sclerosis
Tysabri
Avonex
Betaserone
Rebif
Copaxone
Methylprednisone

Sedative- Hypnotics
Alprazolam (Xanax)
Buspirone (Buspar)
Clonazepam (Klonopin)
Clorazepate (Tranzene)
Diazepam (Valium)
Lorazepam (Ativan)
Chlordiazepoxide hydrochloride (Librium)

MAO Inhibitors
Pheneizine (Nardil)
Tranylcypromine (Parnate)
Isocarboxazid (Marplan)

Narcotic Analgesics
Bupenorphine (Suboxone)
Codeine (Tylenol 3)
Butorphanol (Stadol)
Fentanyl (Duragesic)
Hydrocodone (Lortab,Lorcet)
Hydromorphone (Dilaudid)
Demerol
Methadone (Dolophine)
Morphine (MS Contin, Kadian)
Nalbuphine (Nubain)
Dolophine (Methadone)
Oxymorphone (Opana)
Oxycodone (Percocet)
Oxycontin
Propoxyphene (Darvocet)

Epileptic Medications
Phenobarbital
Levetiracetam (Keppra)
Phenytoin (Dilantin)
Carbamazepine (Tegretol)
Oxcarbazepine (Trileptal)
Lamotrigine (Lamictal)
Gabapentin (Neurontin)

SSRI's
Citalopram (Celexa)
Escitalopram (Lexapro)
Fluoxetine (Prozac)
Paroxetine (Paxil)
Sertraline (Zoloft)

NSAID's
Diclofenac Potassium (Cataflam)
Diclofenac Sodium (Voltaren)
Ibuprofen (Advil, Motrin, Nuprin)
Meloxicam (Mobic)
Naproxen (Naprosyn)
Naproxen Sodium (Aleve)

Beta-Blockers
Atenolol (Tenormin)
Carvedilol (Coreg)
Metoprolol (Lopressor)
Propranolol (Inderal)
Timolol (Blocadren)

Migraine Medications
Almotriptan Malate (Axert)
Dihydroergotamine (Migranal)
Eletriptan (Relpax)
Ergotamine (Cafergot)
Frovatriptan (Frova)
Naratriptan (Amerge)
Methysergide (Sansert)
Rizatriptan (Maxalt)
Sumatriptan (Imitrex)
Treximet
Topiramate (Topamax)
Valproic Acid (Depakote)

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