CNHPC

Comprehensive Neurology, Headache & Pain Center

- TRANSCRANIAL DOPPLER WITH BUBBLE (FOR PFO)
- VIDEO ELECTRONYSTAGMOGRAPHY (VENG)
- ELECTROENCEPHALOGRAPHY
- CAROTID ULTRASOUND
- ELECTROMYOGRAPHY
- EVOKED POTENTIALS
- SLEEP STUDIES
- 24 HOUR EEG

BHARAT M. TOLIA, M.D., P.C., F.A.A.N.
Diplomate, American Board of Neurology

Name:
Date:

1. **Complete the following:**

   height________ age___________
   weight _______ male/female____

2. **Do you have high blood pressure?**
   - ☐ yes
   - ☐ no
   - ☐ don't know

3. **Do you snore?**
   - ☐ yes
   - ☐ no
   - ☐ don't know

if you snore:

4. **Your snoring is?**
   - ☐ slightly louder than breathing
   - ☐ as loud as talking
   - ☐ louder than talking
   - ☐ very loud. Can be heard in adjacent rooms.

5. **How often do you snore?**
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

6. **Has anyone noticed that you quit breathing during you sleep?**
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

7. **During your wake time, do you feel tired, fatigued or not up to par?**
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

2550 Telegraph Road, Suite 235 • Bloomfield Township, MI 48302
(248) 334-0115 • FAX (248) 334-3338
Website: www.cnhpc-michigan.com • E-mail: bmtolia@aol.com

1. In the present or recent past, how likely would it be for you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, try to estimate how they would have affected you. Use the following scale to choose the most appropriate response for each situation.

SITUATION	CHANCE OF DOZING			
	Would never doze	Slight chance of dozing	Moderate chance of dozing	High Chance of dozing
a) sitting and reading	___	___	___	___
b) watching TV	___	___	___	___
c) sitting inactive in a public place (e.g., a theater)	___	___	___	___
d) as a passenger in a car for an hour without a break	___	___	___	___
e) lying down to rest in the afternoon when circumstances permit	___	___	___	___
f) sitting and talking to someone	___	___	___	___
g) sitting quietly after a lunch without alcohol	___	___	___	___
h) in a car, while stopped for a few minutes in traffic	___	___	___	___
i) in a car, while driving your vehicle	___	___	___	___

2. Do you have any of the following sleep abnormalities?

☐ Insomnia (a sleeping disorder characterized by persistent difficulty falling asleep or staying asleep despite the opportunity)
☐ No
☐ Yes
☐ Do not know

☐ Sleep Apnea (a sleeping disorder characterized by pauses in breathing during sleep)
☐ No
☐ Yes
☐ Do not know

☐ Narcolepsy (a sleeping disorder characterized by overwhelming drowsiness and sudden attacks of sleep)
☐ No
☐ Yes
☐ Do not know

11. Confusion or loss of consciousness? ☐ YES ☐ NO ☐ Constant ☐ In episodes
12. Difficulty with speech? ☐ YES ☐ NO ☐ Constant ☐ In episodes
13. Difficulty with swallowing? ☐ YES ☐ NO ☐ Constant ☐ In episodes
14. Tingling around mouth? ☐ YES ☐ NO ☐ Constant ☐ In episodes
15. Spots before eyes? ☐ YES ☐ NO ☐ Constant ☐ In episodes
16. Do you get dizzy after exertion or overwork? ☐ YES ☐ NO
17. Did you get new glasses recently? ☐ YES ☐ NO
18. Do you tend to get upset easily? ☐ YES ☐ NO
19. Do you get dizzy when you have not eaten for a long time? ☐ YES ☐ NO
20. Is your dizziness connected with your menstrual period? ☐ YES ☐ NO

Comments:

CNHPC
Comprehensive Neurology, Headache & Pain Center

BHARAT M. TOLIA, M.D., P.C. F.A.A.N.

Student ______________ Age ______ D.O.B. ______ Date ______

Rate EVERY statement by placing the appropriate number which most fits the student's behavior in the box opposite the statement.

1 You have not noticed this behavior before.
2 You have noticed this behavior to a slight degree.
3 You have noticed this behavior to a considerable degree.
4 You have noticed this behavior to a large degree.
5 You have noticed this behavior to a very large degree.

1. Fails to complete assigned tasks. ☐
2. Often acts before thinking. ☐
3. Runs or climbs a great deal. ☐
4. Gets mad easily. ☐
5. Is a poor reader. ☐

6. Doesn't seem to listen or pay attention. ☐
7. Shifts excessively from one activity to another. ☐
8. Has difficulty staying seated. ☐
9. Shows anger when told to do something. ☐
10. Is a poor speller. ☐

11. Poor concentration on difficult tasks. ☐
12. Can't seem to organize school work. ☐
13. Has difficulty sitting still; fidgets. ☐
14. Is easily frustrated. ☐
15. Does not follow verbal directions. ☐

16. Doesn't stick to just one play activity. ☐
17. Needs a lot of supervision to complete tasks. ☐
18. Moves excessively during sleep or "rocks" in daytime. ☐
19. Loses temper easily. ☐
20. Handwriting is poor. ☐

21. Is distracted easily. ☐
22. Interrupts or speaks out of turn. ☐
23. On the go much of the time; as driven by a motor. ☐
24. Can't take teasing. ☐
25. Has difficulty in completing homework. ☐

Total vertical columns above numbers. ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

______________ Person rating student.

______________ Relationship to child.

Bharat M. Tolia, MD
44200 Woodward Ave, Ste. 215
248-334-0115 phone
248-334-3338 fax

Date:

Patient:
DOB: Gender:

1.How long have you been having headaches?

2. How often do you get headaches? (Please circle one)

ı. Daily b. Several times a week
:. Several times a month d. Once a month
ɜ. Less frequently

3. How severe are you headaches? (Please circle one)
ı. Mild annoyance
ɔ. Uncomfortable enough to require medication
:. Incapacitating

Pain scale (please circle one, 1 being the lowest level of pain and 10 being the highest)
) 1 2 3 4 5 6 7 8 9 10

4. In what area of your head is your pain located?

5. Describe your pain: (please circle)

.. Pounding b. Sharp pain c. Exploding d. Dull ache
:. Gripping f. Pressure g. Other ______________________

ı. How long doe s your headache last?

'. At what time of day does your headache usually occur?

:. Does anything unusual happen prior to your headaches? (please circle choices)
. Numbness or tingling in your extremities b. Visual problems
. Dizziness d. other______________________

'. Do you have any other symptoms during your headaches? (Please circle choice/s)
. Nausea b. Vomiting c. sensitivity to light/Sound d. Other______________

0. During a headache, what would you like to do most? ______________________

1. Is there a relationship between headaches and the foods you eat? YesNo
f so list food: ____

2 Is there a relationship between your headaches and your menstrual cycle? Yes No

3. Generally, how long will 100 over the counter pain tablets last you? ______________

BHARAT M. TOLIA, M.D.

PATIENT REGISTRATION FORM

DATE: ______________________ REFERRED BY: ______________________________________

PATIENT NAME: ____

RESPONSIBLE PARTY (IF A MINOR): ____

STREET ADDRESS: ______________________________ PHONE NUMBER: ______________

CITY ________________________ STATE: ____________________ ZIP: _______________

SEX: ___M___F___ AGE: ______ Birthdate: ____

PATIENT EMPLOYED BY: ____

OCCUPATION: ____

BUSINESS PHONE: ____

EMERGENCY CONTACT (OTHER THAN SPOUSE): ___________________________________

PHONE: ____

SOCIAL SECURITY NUMBER: ____

SPOUSE'S SOCIAL SECRITY NUMBER: ____

DO YOU HAVE MEDICAL INSURANCE: ___YES___NO___ WORK COMP. __________ Auto __________

NAME OF PRIMARY INSURER: ____

CONTRACT NUMBER: ____________________________ GROUP NUMBER: ________________

SUBSCRIBER NUMBER: __________________________ CLAIM ID NUMBER: ______________

SECONDARY INSURANCE: ____

ADDRESS: ____

HOW DID YOU LEARN ABOUT OUR PRACTICE? ______________________________________

ASSIGNMENT RELEASE:

I THE UNDERSIGNED, HAVE INSURANCE WITH: _____________________________________

NAME OF INSURANCE

AND ASSIGN DIRECTLY TO DR. BHARAT TOLIA ALL MEDICAL BENEFITS (IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED.) I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL OF MY INSURANCE SUBMISSIONS.

______________________________ ______________________________

DATE SIGNATURE OF INSURED/GUARDIAN

REVIEW OF SYSTEMS QUESTIONAIRE COMPLETED BY: (STAFF) (PATIENT) (PHYSICIAN) ON __/__/__

NAME: (MALE) (FEMALE)

Adult History and Review of Systems Questionnaire

Note: This is a confidential record of your medical history. As your doctors, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent.

Name ______________________ Date ______________________

Date of Birth __________ ☐ Male ☐ Female

Spouse\Significant Other ______________________

SOCIAL HISTORY:

Birthplace ______________________ Your Occupation ______________________

Nationality ______________________ Education ______________________

Religion ______________________ Marital Status __________ How many years ______

Drug Use ______________________ Children ______________________

Tobacco Use ☐ Yes ☐ No Type ______

Packs per day ____ for ____ years Quit ______

Pets ______________________

Exercise (type/how often?) ______________________

Alcohol Use ______________________

Recent or Frequent Travel Destinations ______________________

Drinks ____ per ☐ day ☐ week ☐ month

If heavy use, how many years ____ Quit ______

Caffeine (coffee, tea, soda, chocolate) Servings per day ______

Have YOU ever had? (IF YES, CHECK APPROPRIATE BOXES)

- ☐ Cancer Type: ______
- ☐ Heart Attack/Coronary
- ☐ Artery Disease
- ☐ Rheumatic Fever
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Gallstones
- ☐ Liver Disease
- ☐ Hepatitis/Jaundice
- ☐ Ulcer disease
- ☐ Heartburn / Reflux
- ☐ Asthma
- ☐ Seizures
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Positive TB Skin Test
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gout
- ☐ Frequent Bladder Infection
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Polio
- ☐ Chicken Pox
- ☐ Infectious Mono
- ☐ Anemia
- ☐ Frequent Sinus Infections
- ☐ Glaucoma
- ☐ Thyroid Trouble
- ☐ Hives
- ☐ Depression
- ☐ Head Injury
- ☐ Broken Bones
- ☐ Blood transfusions
- ☐ Sexually Transmitted Diseases: Herpes, HIV,
- ☐ Gonorrhea, Chlamydia,
- ☐ Syphilis
- ☐ Intravenous drug abuse
- ☐ Needle injury
- ☐ Mumps
- ☐ Migraines
- ☐ Prostate Enlargement
- ☐ Cystic Fibrosis
- ☐ Malaria
- ☐ Other ______

IMMUNIZATIONS:

- ☐ Measles, Mumps and Rubella Vaccine
- ☐ Chicken pox vaccine
- ☐ Hepatitis B vaccine
- ☐ Influenza vaccine
- ☐ Pneumococcal vaccine
- ☐ Tetanus booster

PAST SURGICAL HISTORY: If yes, please check the box and enter the year.

- ☐ Eyes (Laser or Vision Corrected) ______
- ☐ Eyes (Cataract/Glaucoma) ______
- ☐ Ears ______
- ☐ Sinus/Nasal Septum ______
- ☐ Tonsils/Adenoid ______
- ☐ Thyroid ______
- ☐ Heart ______
- ☐ Stomach ______
- ☐ Varicose Veins ______
- ☐ Gall Bladder ______
- ☐ Appendix ______
- ☐ Intestine/Colon ______
- ☐ Hemorrhoids ______
- ☐ Hernia ______
- ☐ Breast ______
- ☐ Uterus/Hysterectomy ______
- ☐ Ovaries ______
- ☐ Spinal Surgery/Neck ______
- ☐ Prostate ______
- ☐ Spinal Surgery/Back ______
- ☐ Orthopedic (Hips/ Knee ______
- ☐ Shoulder/ Feet/Hands) ______
- ☐ C-section ______
- ☐ Vasectomy ______
- ☐ Tubal Ligation ______

☐ OTHER ______________________

ALLERGIES and Bad Reactions to Medications: ______________ ______________

MEDICATIONS: Name | Dosage | Times a day

1. ______________
2. ______________
3. ______________
4. ______________
5. ______________
6. ______________
7. ______________
8. ______________
9. ______________
10. ______________

Has anyone in your FAMILY ever had? (If yes check box and list relationship)

- ☐ Cancer & Type ______
- ☐ Diabetes ______
- ☐ Cardiac Dysrhythmia ______
- ☐ Congestive Heart Failure ______
- ☐ Coronary Artery Disease ______
- ☐ Valvular heart Disease ______
- ☐ High Blood Pressure ______
- ☐ High Cholesterol ______
- ☐ Stroke ______
- ☐ Kidney stones ______
- ☐ Kidney disease ______
- ☐ OTHER ______________
- ☐ Dialysis ______
- ☐ Chronic lung disease ______
- ☐ Tuberculosis ______
- ☐ Rheumatoid Arthritis ______
- ☐ Thyroid trouble ______
- ☐ Osteoporosis ______
- ☐ Cystic Fibrosis ______
- ☐ Asthma ______
- ☐ Peptic Ulcer ______
- ☐ Gallstones ______
- ☐ Crohn's/colitis ______
- ☐ Alzheimer's ______
- ☐ Alcoholism ______
- ☐ Bleeding tendency ______
- ☐ Anemia ______
- ☐ Gout ______
- ☐ Depression ______
- ☐ Mental illness ______
- ☐ Seizures ______
- ☐ Migraine headaches ______

GYNECOLOGICAL/ OBSTETRICAL HISTORY:

Name of OB-GYN ______________

Age when you Started Menstruating? ______

Date of Last PAP? ______

History of abnormal Pap's Yes / No (Please circle)

Date of Last Mammogram? ______

History of Abnormal Mammograms Yes / No (Please circle)

Menstrual Cycles? Regular / Irregular (Please Circle)

Pain with Periods? Yes / No (Please Circle)

Age at Menopause?

Number of Pregnancies? ______

Number of Births? ______

Vaginal / C-section (Please Circle)

Method of Contraception ______

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain >10 pounds
- ☐ Weight Loss >10 pounds

SKIN
- ☐ Nail Changes
- ☐ New Lesions
- ☐ Rash
- ☐ Skin Color Changes

HEENT
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Decreased Hearing
- ☐ Earache
- ☐ Ear Ringing
- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat

NECK
- ☐ Neck Pain
- ☐ Swollen Glands

RESPIRATORY
- ☐ Chronic Cough
- ☐ Decreased Exercise Tolerance
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Sputum Production
- ☐ Wheezing

BREAST
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Skin Changes

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Pains with walking
- ☐ Leg Swelling
- ☐ Night Awakening due to trouble Breathing
- ☐ Palpitations
- ☐ Shortness of Breath

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Trouble Swallowing

GENITOURINARY
- ☐ Vaginal Discharge
- ☐ Menstrual Irregularities
- ☐ Difficulty Starting/Stopping urinary Stream
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Nighttime Urination
- ☐ Urinary Retention
- ☐ Urethral Discharge
- ☐ Impotence
- ☐ Penile Lesions
- ☐ Testicular Mass
- ☐ Testicular Pain

MUSCULOSKELETAL
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Muscle Aches/Pains

NEUROLOGICAL
- ☐ Loss of Bowel Control
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing Out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in Sleep Pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal Thoughts

ENDOCRINE
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

COMPREHENSIVE NEUROLOGY HEADACHE AND SLEEP CENTER

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, ____________________________, have received a copy of Comprehensive Neurology Headache and Sleep Centers, the office of Dr. Bharat Tolla, Notice of Privacy Practices.

____ __________________

Signature of Patient of Legal Guardian Date

____

Patients Date of Birth

HIPPA Compliant Authorization to use or Disclose Protected Health Information (PHI)

NAME:______________________DOB:____/____/____SSN#____________
Address:______________________ Phone# (___)____________
City:______________State:__________ZIP:____________

I hereby authorize______________________(name of facility) Phone#__________
to disclose medical record information and/or protected health information (PHI)of the above listed patient to: Patient Information

Requestor's Name:______________________Phone# (___)__________
Requestor's Address:______________________Fax# (___)__________
City:______________ State:________ Zip:__________

Disclose the following protected health information for treatment dates________to__________

The above information is disclosed for the following purposes:

Medical____ Legal____ Insurance____ Personal ____ Other______________

Office notes____ Test results_____ Insurance______

Radiology_____ Entire chart_____ Labs/Pathology_______

I __________acknowledge and hereby consent to such, that the release of information may
(Initials) contain alcohol/drug abuse, psychiatry, HIV, AIDS information or genetic information.

This authorization shall expire 6 months after signed unless otherwise notated. EXP date:__________

- I understand I have the right to revoke this authorization at any time. I understand that if I do revoke this authorization I must do so in writing and that the revocation will not apply to any information that has already been released to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.
- Fee/Charges will comply with all laws and regulations applicable to release of information
- I understand authorizing the use or disclosure of the information identified above is voluntary, I need not sign this form to ensure healthcare treatment by this facility or any other facility.
- A photocopy of this authorization shall be considered as effective and valid as the original.
- I understand I may refuse to sign this authorization.

Signature:______________________ Date:______________
Signature of witness:______________________ Date:______________

ATTENTION

There will be a $50.00 charge for the following:

- Walking out of a scheduled appointment
- Not showing up for a scheduled appointment
- Cancelling without a 24 hour notice
- Being unable to keep your appointment due to lack of referral

All sleep studies and 72 hour EEG's MUST be cancelled 48 hours in advance.

There is a $150.00 cancellation/no show charge for sleep studies and 72 hour EEG's.

There is a $50.00 cancellation/no show charge for testing appointments (includes all ultrasounds, EMG's and 1 hour EEG's, and NeuroTrax)

There is a $50.00 charge for all forms and letters

The charge of medical records will be decided on per State of Florida or Michigan Guideline.

Fee/Balances MUST be paid in full before being completed

NO PRESCRIPTIONS WILL BE GIVIEN WITHOUT AN APPOINTMENT.

______________________________ SIGNATURE

________________ DATE

Letter of Understanding

I_____________________________understand that I am required to keep all scheduled appointments.

NO prescriptions will be refilled if appointments are not kept.

I will be responsible for all health consequences from not keeping my appointment.

Thank You,

Dr. Tolla

_______________________________ Signature

____________________ Date