Vincent Macaluso MD

Intake Form

DEMOGRAPHICS

Date_____

First Name_____ **M.I.** _____ **Last Name**_____

Date of Birth: _____ **Social Security Number:** _____

Address _____ **Apt.** _____

City and State _____ **Zip Code** _____

Email Address: _____ **Marital Status**: _____

Phone: HOME _____ CELL_____

WORK _____ **Which is your primary number?** H___ W ___ C___

Primary Insurance: _____ **Secondary:** _____

ID & Group # _____ ID & Group #_____

Policy Holder Name _____ Policy Holder Name _____

Policy Holder SSN _____ Policy Holder SSN _____

Policy Holder DOB _____ Policy Holder DOB _____

Primary Care Doctor's Name: _____

Address _____ Phone Number _____

_____ Fax Number _____

Referring Doctor's Name:_____

Address _____ Phone Number _____

_____ Fax Number _____

Pharmacy's Name: _____

Phone Number _____ Fax Number _____

MS HISTORY

1. Which hand do you usually write with? Right___ Left ___
2. When did the symptoms of your MS start (Month/Year)?_____
3. What were those symptoms?_____
4. When were you diagnosed with MS (Month/Year)?_____
5. What were the symptoms at the time of diagnosis?_____

_____

6. If you were you started on a disease modifying therapy (DMT) when you were diagnosed, what drug was it? (e.g. Copaxone, Tysabri, Avonex etc.) _____

7. If you started a DMT but then switched or stopped taking medication, please list below:

Medication & Reason for stopping	**Start date**(MM/YY)	**Stop** (MM/YY)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medication are you CURRENTLY on to slow down your MS? _____

Have you ever been treated with intravenous steroids? YES___ NO___

Have you ever been treated with ACTHar? YES___ NO___

Please check off any of the following that you have now or have had:

VISUAL LOSS: right eye blind___ right eye partial___ left eye blind___ left eye partial___

WEAKNESS:
On the right: face___ arm___ leg___
On the left: face___ arm___ leg___

TINGLING (PINS & NEEDLES):
On the right: face___ arm___ leg___ abdomen___ back___
On the left: face___ arm___ leg___ abdomen___ back___

LACK OF SENSATION:
On the right: face___ arm___ leg___ abdomen___ back___
On the left: face___ arm___ leg___ abdomen___ back___

INCOORDINATION:
On the right: face___ arm___ leg___
On the left: face___ arm___ leg___

Please check any of the following items that you have trouble with:

Cognitive Changes:
Memory___ Concentration___ Processing speed___ Word production___ Initiative___
Emotional Control:
Rapid mood swings___ Apathy___ Anxiety___ Depression___ Irritability___
Sex:
Sexual interest___ Sexual arousal___ Orgasm___ Sexual satisfaction___
Bowel:
Fecal urgency___ Constipation___ Fecal incontinence___
Bladder:
Urinary urgency___ Urinary frequency___ Urinary hesitancy___ Urinary incontinence___

REVIEW OF SYSTEMS

Please check only those that apply. Otherwise **LEAVE THE ITEM BLANK**.

General symptoms

___ Weight gain – how much? ____
___ Weight loss – how much? ____
___ Eating a lot
___ Drinking a lot
___ Bleeding problems
___ Cold intolerance
___ Heat intolerance
___ Fatigue
___ Fever
___ Hot flashes
___ Night sweats
___ Swollen glands
___ Recent infection
___ TB exposure
___ Transfusions
___ Trauma

Neurological

___ Clumsiness
___ Double vision
___ Extreme fatigue
___ Falls
___ Flipping word order
___ Confusion
___ Disorientation
___ Dizziness
___ Seizures
___ Slurred speech
___ Syncope
___ Tremor

Psychiatric

___ Hallucinations
___ Insomnia
___ Restlessness
___ Suicidal Ideation
___ Schizophrenia
___ Bipolar disease

Musculoskeletal

___ Painful joints/Arthralgia
___ Joint Stiffness/Swelling /Arthritis
___ Upper back pain
___ Mid back pain
___ Lower back pain
___ Arm swelling
___ Leg swelling
___ Arm pain
___ Leg pain
___ Heel pain
___ Hip pain
___ Trouble with walking
___ Muscle ache
___ Muscle pain
___ Muscle cramps
___ Muscle twitching

Eyes

___ Blurred vision
___ Pain behind eye
___ Wear glasses
___ Wear contacts
___ Tearing
___ Exudates
___ Red eyes
___ Glaucoma
___ Cataracts

Ears, Mouth, Nose and Throat

___ Loud sounds bother you
___ Ear pain
___ Ringing in ears
___ Ear drainage
___ Dental problems
___ Tooth pain
___ Tongue pain
___ Drooling
___ Bad breath
___ Dry mouth
___ Oral ulcerations
___ Pain with eating
___ Trouble with eating
___ Runny nose
___ Post nasal drainage
___ Sinus problems
___ Excessive sneezing
___ Pain with swallowing
___ Trouble with swallowing
___ Facial pain

___ Sore throat

Neck

___ Hoarseness
___ Limited motion
___ Pain
___ Swelling

Cardiovascular

___ Chest pain
___ Murmur
___ Palpitations
___ High blood pressure
___ Heart trouble
___ Arrhythmia
___ Palpitations
___ Swelling of feet/ankles
___ Phlebitis

Respiratory

___ Cough
___ Blood in sputum
___ Shortness of breath when sleeping
___ Shortness of breath at rest
___ Bronchitis
___ Chronic cough
___ Emphysema
___ Wheezing

Genitourinary

___ Breast discharge
___ Breast mass
___ Breast pain
___ Dark urine
___ Genital ulcers
___ Groin pain
___ Blood in urine
___ Hemorrhoids
___ Getting up at nighttime to urinate
___ Pelvic pain
___ Rectal pain
___ Suprapubic pain
___ Urethral discharge
___ Slow urinary flow

Men

___ Impotence
___ Testicular mass
___ Testicular pain

Abdominal & Gastrointestinal

___ Abdominal pain
___ Belching
___ Diarrhea
___ Flank pain
___ Flatulence
___ Hernia
___ Bloody stools
___ Nausea
___ Vomiting

Skin

___ Tick bite
___ Bruising
___ Cysts
___ Sweatiness
___ Hair problems
___ Jaundice
___ Mole changes
___ Itchiness
___ Rash
___ Skin lesions
___ Varicose veins
___ Hands become blue when cold

PAST MEDICAL HISTORY Please list any medical problems that you have (High Blood Pressure, Diabetes, etc.) If you have or ever had a condition where you needed to be treated with chemotherapy (for arthritis, cancer, etc.) please list the chemotherapy that was used.

_____

_____

_____

_____

SURGICAL HISTORY Please list any surgeries & dates that you had them.

MONTH/YEAR **SURGERY –** If applicable, please mention which side of the body was operated on.

_____ _____

_____ _____

_____ _____

_____ _____

YOU

1. Overall, how do you currently feel?

   Excellent___ Pretty good___ Okay___ Blah___ Stick a fork in me 'cuz I think I'm done ___

2. Do you require sedation for MRI's because of claustrophobia? YES___ NO___
3. How tall are you? ____feet _____inches
4. How much do you weigh?_____lbs.
5. What are some things you like to do? _____

   _____

6. What is the biggest problem that MS presents you with? _____

   _____

SOCIAL HISTORY

1. Are you currently working? YES___ NO___

   If **NO**, are you retired? YES___ NO___

   If **NO,** are you on disability? YES___ NO___

2. What is or was your occupation? _____

3. Do you drink alcohol? YES___ NO___

If **YES**, how much & how often? _____

4. Do you smoke? YES___ NO___

If **NO**, have you ever? YES___ NO___

If **YES**, **how many packs per day** did you or do you smoke?

___ ¼ pack ___ ½ pack ___ 1 pack ___ 2 packs ___ 3 packs ___ 4 packs ___ 5 or more

If **YES**, what year did you start smoking? _____

If you quit smoking, when did you quit? _____

5. Do you get your heart rate up for 30min, at least 5 times a week? (In the 140-160 beats per minute range where you sweat & breath heavily.) YES___ NO___

6. Do you eat at least 5 fruits and/or vegetables a day? YES___ NO___

7. Do you drink 1-2 liters of water per day? YES___ NO___

8. Are you currently in physical therapy? YES___ NO___

9. Are you a student? YES___ NO___

If **YES**, where and what are you studying? _____

10. Check off all that you have **completed**: Elementary____ HS____ GED____

Technical/Vocational____ Associate____ Bachelor's____ Master's____ Doctoral____

11. What was your GPA? If you don't know the number, were you an A, B, C or D student? If you were in between, you can write it like "A to B", "C to D", etc. _____

12. How much do you drink of the following?

TYPE	**HOW MUCH**	**HOW OFTEN**
Coffee	_____	_____
Caffeinated Tea	_____	_____
Soda	_____	_____
Water	_____	_____

FAMILY HISTORY If a relative has no medical problem, write "gh" for good health.

Relative	Alive	Deceased	Medical Problems / Cause of Death
Father	______	______	____
Mother	______	______	____
Brother(s)	#_____	#_____	____
Sister(s)	#_____	#_____	____
Daughter(s)	#_____	#_____	____
Son(s)	#_____	#_____	____

Please list any other relatives with chronic disease. (MS, Lupus, Sarcoidosis, etc.)

Please check off if you are _____adopted or _______a foster child.

ALLERGIES – Please list any allergies that you have.

FOOD:	MEDICATION:	ENVIRONMENTAL:

MEDICATIONS – Please list ALL the meds you are on including vitamins & over the counter meds.

NAME	DOSAGE (MG)	How many times a day/week/month do you take it?

AUTHORIZATION AND RELEASE:

I AUTHORIZE THE RELEASE OF ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYERS, AND/OR OTHER HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DOCTOR ANY INSURANCE OTHERWISE PAYABLE TO ME.

FINANCIAL ARRANGEMENTS:

FOR YOUR CONVENIENCE, WE ACCEPT CASH AND PERSONAL CHECK TOWARD PAYMENT. PAYMENT IN FULL AT EACH APPOINTMENT IS REQUIRED, UNLESS OTHER ARRANGEMENTS ARE MADE. I UNDERSTAND THAT IF AN INSURANCE CLAIM IS DENIED, FOR ANY AND ALL SERVICES RENDERED TO ME (BASED ON ELIGIBILITY), BY MY INSURANCE CARRIER, I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED.

PRINT NAME: _____

SIGNATURE: _____

DATE : _____

Neurocognitive Evaluation Screening Form

Date_____

There are multiple factors that can affect attention. These include disorders such as depression, anxiety, bipolar, dissociative and personality. The following are a series of questionnaires that screen for findings consistent with ADHD as well as for other disorders. It is crucial for your health that you answer the questions honestly so that Dr. Macaluso can treat you appropriately.

Please check the box ☑ if you agree with the statement.

You often overlook or miss details causing you to make careless mistakes when doing your schoolwork, chores or work.	☐
You often have difficulty remaining focused during lectures or conversations or when doing lengthy reading.	☐
You often do not seem to be listening when being spoken to directly (e.g., mind seems elsewhere).	☐
You often fail to follow through on instructions and fail to finish schoolwork, chores or duties at work (e.g. you start tasks but quickly lose focus and are easily sidetracked).	☐
You often have difficulty organizing tasks and activities (e.g. trouble managing sequential tasks; trouble keeping materials and belongings in order; work is messy and disorganized; trouble with poor time management; you fail to meet deadlines).	☐
You often avoid or do not want to engage in tasks that require sustained mental effort (e.g. schoolwork or homework; preparing reports, completing forms, reviewing lengthy papers).	☐
You often lose things necessary for tasks or activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, cell phones).	☐
You often are easily distracted by extraneous stimuli (e.g. people talking; background noise; thoughts about things that have nothing to do with what you are doing).	☐
You often are forgetful in daily activities (e.g. doing chores, running errands; returning calls, paying bills, keeping appointments).	☐

Neurocognitive Evaluation Screening Form

Please check the box ☑ if you agree with the statement.

You often fidget with tap your hands or fingers or squirm in your seat.	☐
You often leave your seat in situations when remaining seated is expected (e.g. leave your place in the classroom the office or other workplace situation).	☐
You often run about in situations where it is inappropriate or feel restless in situations and feel like you want to walk or run around.	☐
You are often unable to play or engage in leisure activities quietly (e.g. are you unable to be, or uncomfortable being, still for extended time, as in restaurants, meetings).	☐
You often talk excessively.	☐
You often blurt out answers before questions have been completed (e.g. you complete other people's sentences; you cannot wait for turn in conversation).	☐
You often have difficulty waiting for your turn (e.g. like when you are waiting in line).	☐
You often interrupt or intrude on others (e.g. you butt into conversations, games, or activities; you start using other people's things without asking or receiving permission; you intrude into or take over what others are doing).	☐

Neurocognitive Evaluation Screening Form

Please check the box ☑ that applies to you.

Over the last 2 weeks, how often have you been bothered by any of the following:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
A. Little interest or pleasure in doing things?	☐	☐	☐	☐
B. Feeling down, depressed, or hopeless?	☐	☐	☐	☐
C. Trouble falling or staying asleep, or sleeping too much?	☐	☐	☐	☐
D. Feeling tired or having little energy?	☐	☐	☐	☐
E. Poor appetite or overeating?	☐	☐	☐	☐
F. Feeling bad about yourself or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
H. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
I. Thoughts that you would be better off dead or of hurting yourself in some way?	☐	☐	☐	☐
		_____	_____ x2	_____ x3

_____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Neurocognitive Evaluation Screening Form

Please check the box ☑ that applies to you.

Over the last 6 months, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it's hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable.	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen.	☐	☐	☐	☐
		_____	_____ x2	_____ x3 _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

If you drink alcohol or use illicit drugs, please check the appropriate boxes:	Yes	No
Have you felt you ought to cut down on your drinking or drug use?	☐	☐
Have people annoyed you by criticizing your drinking or drug use?	☐	☐
Have you felt bad or guilty about your drinking or drug use?	☐	☐
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Neurocognitive Evaluation Screening Form

1. Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money.

Have you ever had a period like this lasting several days or longer? NO__ YES__

If you answered YES to question 1, then please skip to question 3.
If you answered NO to question 1, then please go to question 2.

2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you started arguments, shouted at people or hit people? NO__ YES__

If you answered YES to question 2, then please continue to question 3.
If you answered NO to question 2, then you have finished this questionnaire.

3. People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in many ways they would normally think inappropriate.
Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy? NO__ YES__

If you answered NO to question 3, then you have finished this questionnaire.
If you answered YES to question 3, then please continue the questionnaire.

If you answered YES to question 3 and NO to question 1, please read the statement in italics below and then answer the questions starting at the letter A.

If you answered YES to question 3 and YES to question 1, please read the statement in italics below and then answer ALL the following questions.

Now think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?

- Were you so irritable that you started arguments, shouted at people, or hit people? NO__ YES__

A. Did you become so restless or fidgety that you paced up and down or couldn't stand still? NO__ YES__

B. Did you do anything else that wasn't usual for you - like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing? NO__ YES__

C. Did you try to do things that were impossible to do, like taking on large amounts of work? NO__ YES__

D. Did you constantly keep changing your plans or activities? NO__ YES__

E. Did you find it hard to keep your mind on what you were doing? NO__ YES__

F. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them? NO__ YES__

G. Did you sleep far less than usual and still not get tired or sleepy? NO__ YES__

H. Did you spend so much more money than usual that it caused you to have financial trouble? NO__ YES__

Note to All Patients

Because of the high incidence of controlled substance abuse that is currently going on, before any Class II, III, IV or V medications are dispensed, Dr. Macaluso has to run a Confidential Patient Drug Utilization Profile Report through the New York State Department of Health. It is necessary that you list ALL of the medications that you take and list all of the Doctors, Nurses, Physician Assistants or anyone else who dispenses any controlled substance to you. A controlled substance is any medication that requires a prescription in order to be filled and cannot have refills on it. Some examples include, but are not limited to:

Narcotics

codeine	buprenorphine (Buprenex)	butorphanol (Stadol)
fentanyl (Duragesic)	hydrocodone	hydromorphone (Dilaudid)
levorphanol	meperidine (Demerol)	methadone
morphine	nalbuphine (Nubain)	oxycodone (OxyContin, OxyFast, Roxicodone)
oxymorphone	Pentazocine (Talwin)	propoxyphene

Attention Deficit Disorder Medications

dextroamphetamine /amphetamine (Adderall)	dexmethylphenidate hydrochloride (Focalin)	dextroamphetamine (Dexedrine, Dextrostat)
Lisdexamfetamine (Vyvanse)	methylphenidate hydrochloride (Concerta, Daytrana, Metadate, Methylin, Ritalin)	pemoline (Cylert)

Patient Name: _____

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Controlled Substances Agreement

We are committed to doing all we can to treat your neurological condition. In some cases, controlled substances are used as a therapeutic option in the management of neurological diseases, including, but not limited to, tremors, anxiety, ADHD and chronic pain. These controlled substances are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the practice by establishing guidelines, within the laws, for proper controlled substance use. In this agreement, the words "we" and "our" refer to Vincent F. Macaluso MD PC (which includes Dr. Vincent F. Macaluso and his appointees) and the words "I," "you," "me," or "my" refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below or, during his absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below or, during his absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, including over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or to attempt or obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his staff, or knowingly withholding facts from a physician or his staff (including failure to inform the physician or his staff of all controlled substances that I have been prescribed).

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

NAME: _____

PHONE: _____

3. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed.

4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility.

5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or, during his absence by the covering physician, as set forth in Section 1

Patient Name: _____

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above. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, heroin, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.

6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.

7. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

8. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.

9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and that law enforcement officials may be contacted.

10. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

Patient's Full Name _____

Patient's Signature _____ Date _____

Physician's Signature _____ Date _____

Patient Name: _____

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