HIT-6™ Headache Impact Test

HIT is a tool used to measure the impact headaches have on your ability to function on the job, at school, at home and in social situations. Your score shows you the effect that headaches have on normal daily life and your ability to function. HIT was developed by an international team of headache experts from neurology and primary care medicine in collaboration with the psychometricians who developed the SF-36® health assessment tool. This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please circle one answer for each question.

When you have headaches, how often is the pain severe?

never rarely sometimes very often always

How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

never rarely sometimes very often always

When you have a headache, how often do you wish you could lie down?

never rarely sometimes very often always

In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

never rarely sometimes very often always

In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

never rarely sometimes very often always

In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

never rarely sometimes very often always

☐	☐	☐	☐	☐
COLUMN 1 6 points each	COLUMN 2 8 points each	COLUMN 3 10 points each	COLUMN 4 11 points each	COLUMN 5 13 points each

To score, add points for answers in each column.

If your HIT-6 is 50 or higher:

You should share your results with your doctor. Headaches that stop you from enjoying the important things in life, like family, work, school or social activities could be migraine.

☐
TOTAL SCORE

Headache Questionnaire

Do you have a headache today? Yes No Intensity: 0-1-2-3-4-5-6-7-8-9-10

Age of onset: _____

Trauma related? Yes No

Menstrual cycle related? Yes No Age of onset of menstrual cycle: _____

Triggers:

Food Yes No Explain: _____

Allergies Yes No Explain: _____

Weather Yes No Explain: _____

Stress Yes No Explain: _____

Description:

Average intensity: 0-1-2-3-4-5-6-7-8-9-10

Frequency? _____

How long do they last? _____

Mild headaches _____

How functional are you during headaches? _____

How much work do you miss related to headaches? _____

Light sensitivity Yes No

Sound sensitivity Yes No

Odor sensitivity Yes No

Nausea and/or vomiting Yes No

Aura Yes No Explain:_____

Treatment:

MRI/CT Yes No Explain: _____

ER visits: _____

What do you do for them now? _____

Medications:

Current:_____
_____

Previous:_____
_____

ROBERT UNSELL, M.D.
ORTHOPEDIC HAND & UPPER EXTREMITIES SURGEON

Name:_____ DOB: _____MR#: _____

Age: _____Height: _____ Weight: _____

Primary Care Physician/ Referring Physician Name and Phone Number: _____

Have you ever seen a Cardiologist? YES / NO If yes, who: _____

Reason for Today's Visit: _____

Injury? YES / NO Date of Injury? _____ Work related? YES / NO Auto Accident? YES / NO

Brief Description of Injury: _____

MEDICATIONS List all medications you are currently taking: Prescription and over-the-counter medications (example: aspirin, antacids, sinus & allergy medications, etc)

☐ I AM CURRENTLY NOT TAKING ANY MEDICATIONS

Medication Name	**Dosage**	**Frequency**

PHARMACY List name and location of your preferred pharmacy to use when calling in prescriptions:
Pharmacy: _____ Location / Phone#:_____

ALLERGIES:

☐ I have no known allergies.

Other Allergies	**Describe Reaction** (e.g., hives, rash, itching, nausea, diarrhea, headaches, fainting, shortness of breath, shock, etc.)

Patient Signature _____ **Date** _____

OSSO
OKLAHOMA SPORTS SCIENCE & ORTHOPAEDICS

Jimmy H. Conway Jr., M.D. Robert S. Unsell, M.D. 10001 S. Western, Ste 101 OKC, OK 73139 405-692-3700

PATIENT INFORMATION
(please fill in all blanks)

Patients Legal Name: Last	First	M.I.	Sex:	DOB:	Age:

Social Security Number:	Email Address: Declined ☐	Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single	Spouses Name:

Patients Address:	Employment Status: ☐ Employed ☐ Full-time student ☐ Part-time student ☐ Retired

City:	State:	Zip:	Referring Physician:

Home Phone: ☐ Primary	Work Phone: ☐ Primary	Cell Phone: ☐ Primary	Preferred Language:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

Race: ☐ White ☐ Asian ☐ Black ☐ Pacific ☐ Native American ☐ Multiple ☐ Other

INSURANCE INFORMATION – We will need a copy of the insurance card in order to file a claim.

Name of the Primary Insurance Company_____

Name of the person who carries the insurance policy_____Relationship to Patient_____

Carriers DOB _____ Carriers SS# _____

Carriers Employer_____

Seconday Insurance_____ Relationship to Patient_____

Carriers Name: _____ DOB: _____ Carriers SS# _____

Carriers Employer_____

EMPLOYMENT INFORMATION

N / A ☐ Patients Employer _____ Phone Number _____

N / A ☐ Insured Employer _____Phone Number_____

If Patient is a minor, please list both parents names and employers

N / A ☐ Mother _____ Employer_____ Phone #_____

Father _____ Employer_____ Phone# _____

NEXT-OF-KIN INFORMATION

Nearest Relative (or Friend, Not Souse) Not living with you:

Home Phone: Relationship to patient:

WHO REFERRED YOU TO OUR OFFICE?

Adjuster Attorney Billboard Case Manager Doctor Employer Friend Hospital Insurance Company Magazine
Neighbor Phone Book Coach Physical Therapist School Trainer Radio Other

THIRD PARTY BILLING

Is your injury work related?	YES	NO
Is this injury due to an accident?	YES	NO
If your injury is MVA related, have you obtained an accident report?	YES	NO

I hearby authorize my insurance benefits to be paid directly to the facility and the physician. I acknowledge that I am financially responsible for non covered services. I also authorize the physician to release my informationin the processing of any insurance claims. I acknowledge that I have received a copy of the TPG Privacy Notice.

Signature:	Date:

Chart No: _____

OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS

Authorization to Release Information via phone / Family /Friends

Patient Name: _____ DOB:_____

I hereby authorize confidential communications form the physicians or staff of OSSO regarding my health, care treatments, appointments, prescriptions etc. to be received at any of the numbers given below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand this authorization will remain in effect for one year or unless I revoke the authorization in writing.

Patient Signature: _____ Date: _____

OSSO STAFF ONLY:
Documented by:

_____ _____
Initials Date

Oklahoma Sports Science & Orthopedics

FINANCIAL POLICY

Thank you for choosing Oklahoma Sport Science & Orthopedics as your healthcare provider. At OSSO we are dedicated to providing the highest quality, most cost effective care. We specialize in Adult and Pediatric Orthopedics, Sports Medicine, Physical Medicine and Rehabilitation, Pain Management, Reconstructive and Orthopedics Spine Surgery and Hand Surgery.

In addition to accepting traditional insurance plans and Medicare we are contracted with numerous Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different and constantly updating provider's participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully with all referral, pre-authorization and pre-certification processes. **Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.**

Accurate, up to date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring to each appointment your current insurance card or any other information that is required by your insurance carrier. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductible, and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover Card, American Express or MasterCard. In most cases we can arrange payment plans for patients who have financial concerns. Please notify our office at 692-3700 to make payment arrangements. **Please be aware that charges for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital, ambulatory surgery facilities and some radiology services may be billed separately.**

If your injury was due to a motor vehicle accident you will be set up on a self-pay account for any charges incurred up to $500. If charges exceed $500, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with a third party in order to ensure payment to the physician. **Please note that not all OSSO Physicians will accept third party/ MVA patients.**

There is a $35 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion.

If you require surgery or any other invasive procedures that are scheduled at Community Hospital, Northwest Surgical Hospital or Community Hospital North, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again thank you for allowing Oklahoma Sports Science and Orthopedics to participate in your care.

Sincerely,
OSSO Physicians and Staff

My signature below acknowledges receipts of this Financial Policy:

Signed: _____Date: _____
(Signature of person financially responsible for payment)

Relationship if other than patient: _____

AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Oklahoma Sports Science & Orthopedics to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of Oklahoma Sports Science & Orthopedics to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of Oklahoma Sports Science & Orthopedics charge or who may be responsible in determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Social Security Administration, intermediaries or carriers. **I understand that my medical records may contain information that indicates that I have a communicable disease which may include but is not limited to, disease such as hepatitis, syphilis, gonorrhea or the human immunodeficiency Virus, also known as acquired immune deficiency syndrome (AIDS).** With this knowledge, I give my consent to release all of the information in my medical records, including any information concerning identity, and release Oklahoma Sports Science & Orthopedics, its agents and employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit to Oklahoma Sports Science and Orthopedics. I understand that I am financially responsible for charges not covered by this assignment.

I agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have a balance owing for fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release Oklahoma Sports Science and Orthopedics from any claim for responsibility or damages in the event of loss of my personal property, including, but not limited to, money and jewelry.

I understand a photocopy of this document is as valid as the original.

SIGNED _____ **DATE** _____
(PATIENT)

OR_____
(RESPONSIBLE PARTY OR NEAREST RELATIVE)

POLICYHOLDER'S
_____ **SIGNATURE**_____
(RELATIONSHIP TO PATIENT)

NOTICE TO PATIENTS: information in your medical record that you have / may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk of exposures, release risk of exposures, release pursuant to an order of the court of the Department of Health, release among Healthcare Providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by the order of the court, or the department of health, or by law.

Robert Unsell, M.D.

- The pain you are experiencing may be improved, but not eliminated with use of narcotic pain medication.
- Once pain medications are prescribed you will be required to have regular office visits to assess your pain status. Your medications will not be phoned in should you be unable to keep these appointments.
- This office fills pain medications for surgical patients only. They are not filled indefinitely. After a period of time your doctor will taper your medications for discontinuation. If discontinuation is not possible or you are not a surgical candidate you will be referred for long-term pain management.
- Your treating physician is the only physician who prescribes narcotic pain medication to you.
- It is your responsibility to notify us of any other Physicians who are prescribing narcotic pain medications to you. It is also your responsibility to inform other physicians that we are prescribing a managing you narcotic pain medications.
- Individuals must be aware that "doctor shopping" is viewed as a narcotic drug seating seeking behavior and is not tolerated. Should this type of behavior occur, your narcotic pain medication will not be refilled and you will be dismissed as a patient.
- Excessive calls requesting pain medications or an increase in the dose or frequency of your pain medications is viewed as drug seeking behavior and is not tolerated. You will be asked to make an appointment to see the doctor before any changes are made.
- **Pain medication refill request are taken Monday through Friday from 8:30 a.m. to 3:30 p.m. only. Prescription refills are not taken or called in on Saturday, Sunday, holidays or after hours for any reason.** We guarantee prescription refills will be processed within 72 hours of the request.
- Federal and state law carefully regulates dispensed or written prescriptions for narcotic medications. Forging or altering a narcotic prescription or distributing medications to others of their use or for money is a crime. Such behavior is not tolerated you will be dismissed as a patient and reported to the DEA, police and FDA.
- Lost, stolen or misplace prescriptions or medications **are never replaced - no exceptions.** Your medication and prescriptions are your responsibility.
- There are side effects with narcotic medications, which may include but are not skin rash, constipation, sexual dysfunction, sleep abnormalities, sweating, swelling, sleepiness and/or impaired mental and/or motor ability. Narcotic pain medications may cause sedation and dizziness. You should not drive an automobile or operate any Machinery while taking medications. Overuse of narcotic pain medication can lead to breathing difficulties and even death.

  Informed consent: I _____ have been informed and clearly understand the above-listed issues regarding the treatment of pain with narcotic pain medication I understand that this agreement will be filled will be filed in my chart as part of my permanent medical record.

Signature _____ Date _____

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Robert S. Unsell, M.D. has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Print Name of Patient	Print Name of Parent or Guardian

Date:_____

HPI COMMUNITY HOSPITAL

HPI NORTHWEST SURGICAL HOSPITAL

HPI COMMUNITY HOSPITAL IMAGING CENTER

HPI COMMUNITY HOSPITAL OUTPATIENT THERAPY

HPI NORTHWEST SURGICAL HOSPITAL LAKEPOINTE IMAGING CENTER