716.250.2000 | dentinstitute.com
Amherst | 3980 Sheridan Drive • Amherst, NY 14226
Orchard Park | 200 Sterling Drive • Orchard Park, NY 14127
Buffalo | 40 George Karl Boulevard • Buffalo, NY 14221

Dear Patient:

Thank you for choosing the Dent Neurologic Institute, Western New York's premier Neurologic and Diagnostic Center.

Patients are required to arrive 30 minutes prior to their appointment time for the initial consultation. This time will be used to complete the registration process. Thank you for your understanding!

In order to ensure a positive experience, please be prepared with the following items on the day of your visit. Failure to comply may result in our need to reschedule your visit.

★ **Documents:** You must complete all the enclosed documents prior to your appointment time. COMPLETION OF YOUR MEDICAL INTAKE FORMS IS CRITIAL IN ORDER FOR OUR PHYSICIANS APPROPRIATELY TREAT AND DIAGNOSIS. If your visit is related to a work or motor vehicle accident, you must complete the application forms in their entirety.

★ **Insurance Card:** You must provide us with your insurance card.

★ **Payment:** If you have a co-pay or high deductible plan, you must bring payment with you; if you have a high deductible plan $200 is required at the time of service; any remaining responsibility will be billed to you.

★ **Identification:** You must provide us with photo ID or two other forms of identification.

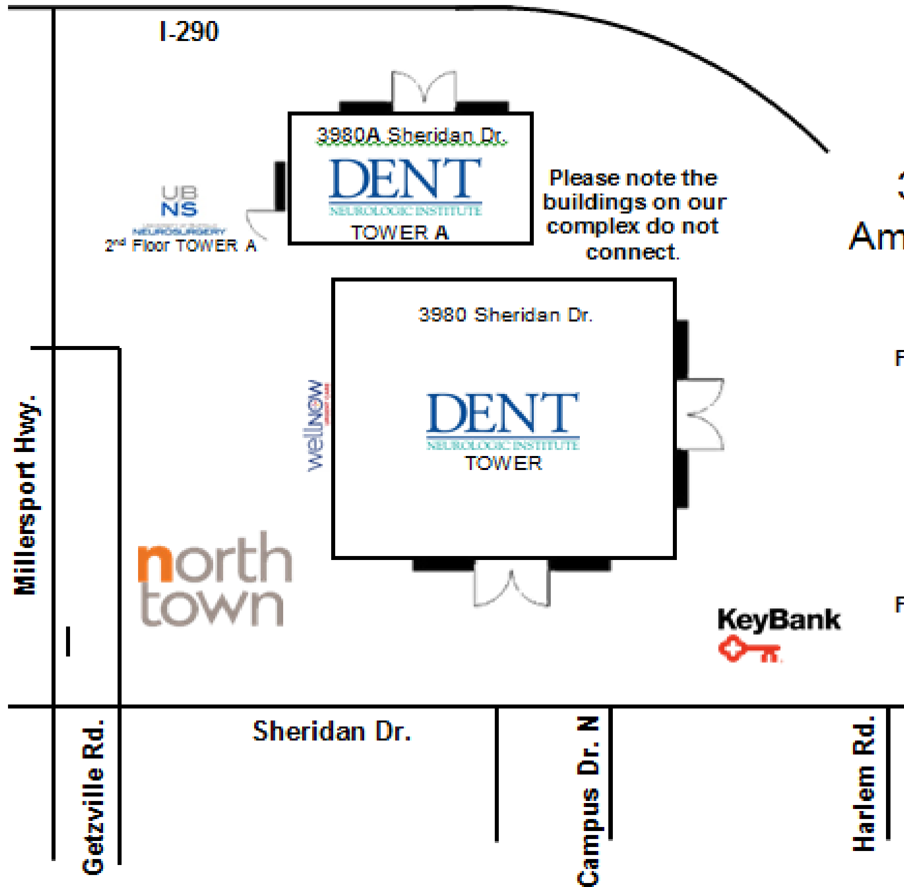
★ **Diagnostic Results:** Test results, diagnostic reports, films and CDs from all physicians treating you are REQUIRED at visit

Be sure to visit our website at www.dentinstitute.com for insurances we accept and access to your on-line secured medical record.

Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call our Center at 716-250-2000.

Advance Notice is Required for all Cancellations

If you fail to cancel an appointment at least one business day prior; or you do not show for your scheduled appointment, you will be assessed a non-timely cancellation fee.



DENT
NEUROLOGIC INSTITUTE

Amherst Location

3980 Sheridan Drive
Amherst, New York 14226

DRIVING DIRECTIONS:

FROM NIAGARA FALLS/NORTHTOWNS

- Robert Moses Parkway South
- I-190 South
- I-290 East

(Youngman Exp/Exit 16 towards I-90)

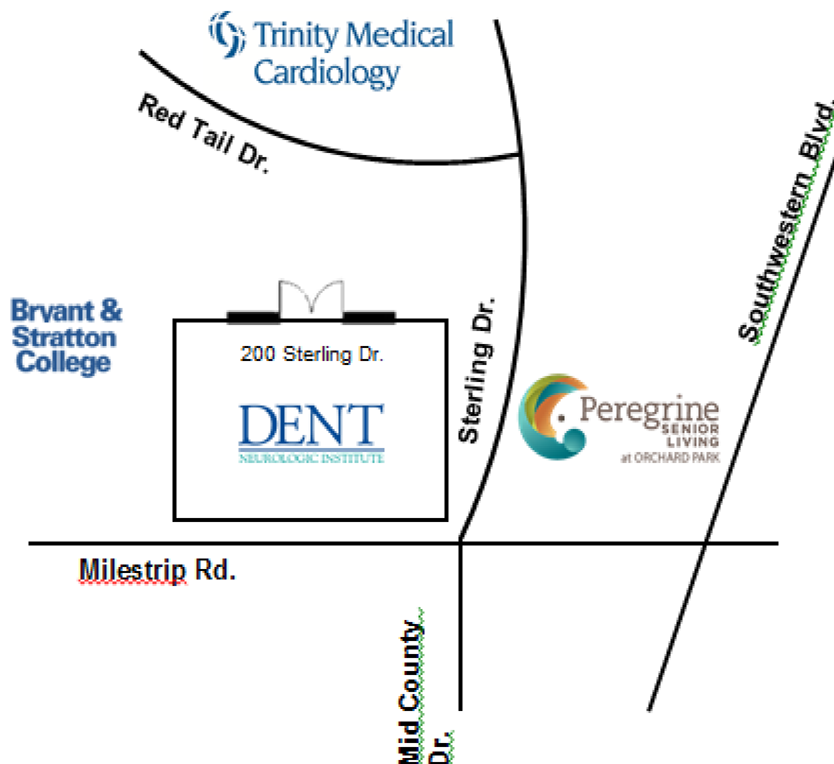
- Exit Harlem Road (Exit 6)
- Right onto Harlem Road
- Left onto Sheridan Drive
- Right at light into Dent Tower

FROM SOUTHTOWNS

- I-I90 East
- Merge into I-290

(Youngman Exp/Exit 50)

- Exit Sheridan Drive (Exit 6)
- Left onto Sheridan Drive
- Right at light into Dent Tower



Orchard Park Location

200 Sterling Drive
Orchard Park, NY 14127

DRIVING DIRECTIONS:

FROM SOUTHTOWNS

- Route 219 N to Milestrip Road East

(1st Exit onto Milestrip Road)

- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM BUFFALO

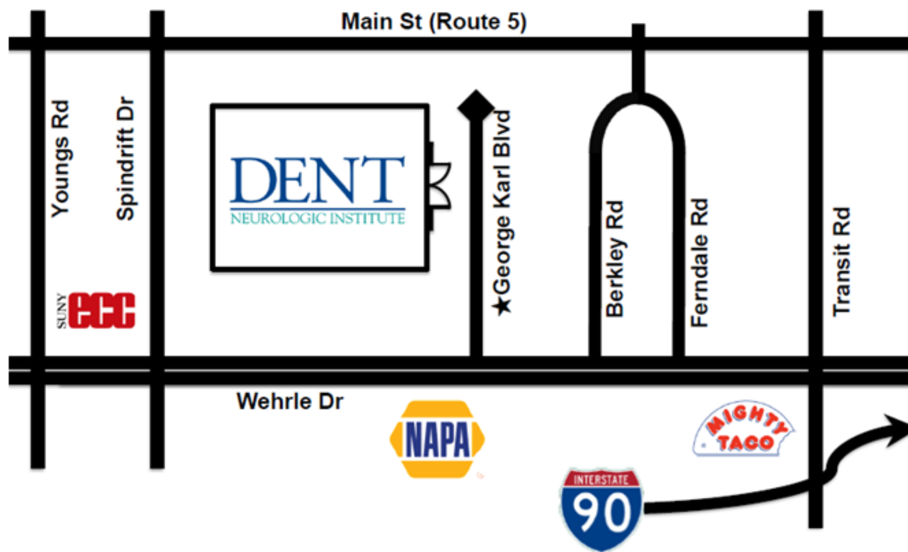
- Thruway (90) West to Route 219
- Exit Milestrip Road East

(2nd Exit onto Milestrip Road)

- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM PENNSYLVANIA

- Thruway (90) East to Exit 56
- Left onto Milestrip Road
- Left onto Sterling Drive
- Left on Red Tail
- Left into parking lot



Buffalo Location
40 George Karl Boulevard
Buffalo, NY 14221
Suite 120

From Niagara Falls

- I-190 South toward Buffalo
- Exit 16 for I-290 East toward Rochester/ Tonawanda
- Take ramp left for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Buffalo

- Route 33 East toward Airport
- Take ramp right for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Southtowns

- Route 219 North toward Buffalo
- Take ramp right for Thruway I-90 East toward Buffalo (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

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DENT NEUROLOGIC INSTITUTE

REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Last Name:	**Middle:**	**First Name:**	
❑ Mr. / ❑ Mrs. / ❑ Miss / ❑ Ms.	**Marital Status (Check one):**	❑ Single / ❑ Married / ❑ Divorced ❑ Separated / ❑ Widowed	
Former Name:	**Preferred Name:**		
Birth Date:	**Sex:** ❑ M ❑ F	**E-mail Address:**	
Home Phone: ( )	**Cell Phone:** ( )		
Street Address or P.O. Box:			
City:	**State:**	**Zip Code:**	**Social Security Number:**
Primary Physician:	**Referring Physician:**		
Race:	**Ethnicity:**	**Language:**	
Pharmacy Name:	**Pharmacy Address:**	**Pharmacy Phone:**	
CONTACT PERSON IN CASE OF EMERGENCY			
Name:	**Relationship:**		
Home Phone: ( )	**Cell Phone:** ( )		
SEXUAL ORIENTATION / GENDER IDENTITY			
Sexual Orientation (Check one):	❑ Lesbian, gay or homosexual / ❑ Straight or heterosexual ❑ Bisexual / ❑ Do not know / ❑ Choose not to disclose		
	Something else, please describe:		
Gender Identity (Check one):	❑ Male / ❑ Female / ❑ Female-to-Male (FTM), Transgender Male, Trans Man ❑ Male-to Female (MTF), Transgender Female, Trans Woman ❑ Genderqueer, neither exclusively male nor female ❑ Choose not to disclose		
	Additional gender category or other, please specify:		

DENT NEUROLOGIC INSTITUTE
INSURANCE INFORMATION

You will need to give your insurance card to the receptionist		
Person Responsible for Bill (if not self):	**Address (if different):**	**Home Phone: ( )** **Cell Phone: ( )**
Birth Date: / /	**Occupation:**	
Responsible Party's Employer:	**Employer Address:**	**Employer Phone:** **( )**

PRIMARY INSURANCE	**Insurance Plan:**			
Policy No:	**Group No:**			
Subscriber's Name (if not self):	**Subscriber's SSN:**		**Co-pay Amount:**	
	Subscribers DOB: / /			
Patient's Relationship to Subscriber (Check one):	❑ **Self**	❑ **Spouse**	❑ **Child**	❑ **Other**
SECONDARY INSURANCE	**Insurance Plan:**			
Policy No:	**Group No:**			
Subscriber's Name (if not self):	**Subscriber's SSN:**			
	Subscribers DOB: / /			
Patient's Relationship to Subscriber (Check one):	❑ **Self**	❑ **Spouse**	❑ **Child**	❑ **Other**

IF YOUR APPOINTMENT IS THE RESULT OF AN ACCIDENT OR INJURY,
YOU MUST COMPLETE THE ENCLOSED NO-FAULT OR WORKERS COMP FORM

PLEASE READ

Important Insurance Plan Information

Before being seen, please review the following insurance participation information. Deductibles, co-insurances and co-pays are due at time of service. Estimated cost of an office visit ranges from $75 - $200; estimates for office procedures will be provided separately. If you have any questions or would like to receive an estimate for services, please call our Business Office at 250-2010.

DENT Participates with:

- Blue Cross Blue Shield (including Align programs)
- Empire
- Fidelis (**Not Accepting New Adult Patients**)
- Independent Health
- MagnaCare (including Health Republic)
- MVP (excluding Individual Exchange plans)
- Nova
- RMSCO (aka Lifetime Benefits Solutions)
- United Healthcare (Commercial and Medicare plans only)
- Univera
- Medicare and Medicare Railroad
- NYS Medicaid
- Wellcare (**Not Accepting New Patients**)
- Excellus - Blue Cross Plans (does not include Medicare Blue Choice Value/ Optimum or Monroe Medicaid plans)
- Martin's Point (varies by doctor)
- YourCare

DENT does NOT Participate with:

- Aetna (unless part of MultiPlan which varies by doctor)
- Cigna (unless part of MultiPlan which varies by doctor)
- Coventry/Health America
- Emblem Health/GHI -Imaging ONLY
- Excellus Plans (Premier Option)
- MVP (Individual Exchange plans)
- MultiPlan (varies by doctor)
- UPMC
- United Healthcare (Medicaid plans)
- Out of State Medicaid

In every case we will bill your insurance carrier on your behalf. Based on participation status you may have additional out-of-pocket expenses. We recommend you call your carrier directly to verify individual physician coverage.

Your insurance carrier may require you to utilize a specific laboratory testing facility. Please be sure to confirm this with the office staff.

Hospital Affiliations: Kaleida Health; Mercy Hospital of Buffalo

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DENT NEUROLOGIC INSTITUTE
WORKERS COMPENSATION
SUPPLEMENTAL INFORMATION FORM

Today's Date:		Date of Birth:
Patient Name:		Social Security No:
Date of Injury:		
Employer Name:		Employer Address:
Employer Phone Number: ( )	Your Job Title:	Are you out of work due to this injury: ❑ Yes ❑ No
COMPENSATION INSURANCE CARRIER INFORMATION		
Insurance Carrier Name:		Insurance Carrier Address:
Carrier Claim Number:		WCB Case Number:
Name of Case Manager:		Phone: ( )
		Fax: ( )
Briefly Describe the Injury you Sustained:		
Briefly Describe how Injury Occurred:		
ATTORNEY INFORMATION		
Attorney Name:		Attorney Address:
Phone: ( )		Fax: ( )

Please bring all Insurance Carrier and Workers Compensation Board information with you to your appointment. We may need to reschedule your appointment should you fail to include critical information concerning your Carrier.

DENT NEUROLOGIC INSTITUTE

NO-FAULT

SUPPLEMENTAL INFORMATION FORM

Patient Name:	Date of Birth:
	Social Security No:
Date of Accident:	Are You Currently Out of Work as a Result of this Accident: ❑ Yes ❑ No
Injury Sustained:	
INSURANCE CARRIER INFORMATION	
Insurance Carrier Name:	Insurance Carrier Address:
Name of Adjuster:	Claim Number:
Phone: ( )	Fax: ( )
ACCIDENT DETAILS	
Location of Accident:	
Briefly Describe how the Accident Occurred:	
Were you a: ❑ Driver ❑ Passenger ❑ Pedestrian	
If Driver or Passenger, were you: ❑ Belted ❑ Not-Belted	
Have you Filed a Claim with your Carrier: ❑ Yes ❑ No	Have you Completed and Returned your No-Fault Application: ❑ Yes ❑ No
ATTORNEY INFORMATION	
Attorney Name:	Attorney Address:
Phone: ( ) Fax: ( )	
Signature:	**Date:**
FOR OFFICE USE ONLY	
PROVIDER: **DENT NEUROLOGIC GROUP** **PO Box 8000 Dept 057** **Buffalo, NY 14267** **Signature: ____________________________**	**CLAIM# ____________________** **DATE OF LOSS: ________________** **CARRIER: ___________________**

DENT NEUROLOGIC
NEW PATIENT HISTORY FORM

Today's Date _______________

Name: ______________________________ DOB: _______________ Age: _________

1. Please describe the problem that you would like addressed, e.g., what it consists of, how and when it started, what worsens and relieves it.

____
____
____
____
____

2a. Who is your **primary physician with address** (if known)?

____
____

2b. What physicians have you seen for this problem?

____
____

3. List all illnesses and/or hospitalizations/surgeries you have had during your life:

______________________________ ______________________________________
______________________________ ______________________________________
______________________________ ______________________________________
______________________________ ______________________________________

4. List the <u>name and dose for each</u> prescription and over-the-counter medication you are <u>currently</u> taking:

Drug:	**Dose:**

5. Any drug allergy?

<u>Drug</u>	<u>Reaction</u>

6. What has been done for your problem? Medications? Physical therapy? Surgery? Other?

Treatment	Date	Results
________________________	_______________	____________________________________
________________________	_______________	____________________________________
________________________	_______________	____________________________________
________________________	_______________	____________________________________

7. Other problems? Please **circle** the ones that apply to you:

Neurologic
Headache, change in taste, smell or hearing, slurred speech, difficulty swallowing, dizziness, weakness, numbness, loss of consciousness, fainting, seizure, unsteadiness, falls, tremor, confusion, memory loss, head trauma, sleep problem, stroke/TIA (mini-stroke)

Constitutional
Fever, chills, fatigue, weight gain or loss, HIV/AIDS

Eyes
Blurry vision, double vision, decreased vision, cataract, glaucoma

Ears, Nose, Mouth, Throat
Hearing loss, ringing in the ears, earache, hoarseness, vertigo (spinning)

Cardiovascular
Chest pain, palpitations, leg edema, high blood pressure, heart attack, coronary artery disease/surgery, shortness of breath when lying down or on exertion, heart failure.

Respiratory
Cough, emphysema, asthma.

Gastro-Intestinal
Nausea, vomiting, heartburn, ulcers, abdominal pain, diarrhea, constipation, hepatitis

Genito-Urinary
Urinary incontinence/frequency/urge, sexual dysfunction, kidney problems

Skin
Rash or other skin abnormality

Musculoskeletal
Joint pain/swelling/stiffness, neck/lower back pain, muscle aches

Psychiatric
Depression, anxiety, other psychiatric problems

Print Name: ______________________________________

Continued from # 7

Endocrine
Diabetes, thyroid problems, hormonal problems

Hematologic
Anemia, easily bruises, bleeding disorder.

Allergy
Itching, rash, swollen lips/tongue.

Have you ever had cancer? ____ No ____ Yes, describe __________________________

8. Have you had any of the following tests?

Test	Date	Where
MRI	______________	_________________________________
CT	______________	_________________________________
Carotid Doppler	______________	_________________________________
EMG	______________	_________________________________
EEG	______________	_________________________________
SPECT/PET	______________	_________________________________
Other (myelogram, angiogram, biopsy, spinal tap):		
______________________	______________	_________________________________
______________________	______________	_________________________________
______________________	______________	_________________________________
______________________	______________	_________________________________

9. Do you use tobacco? ___ No ___Yes, pack per day ___, # of years____ Quit date ______

Do you use alcohol? ___ No ___ Yes, amount ______________________________

Who lives with you at home? ____

Describe your work: ____

____

Disability? _______ No ________ Yes, since _____________________________

10. Have you fallen in the past 12 months? ___ No ___Yes

Do you feel unsteady when standing or walking? ___ No ___ Yes

Print Name: _________________________________

11. Tell us about your family's health:

Mother: ____

Father: ____

Brother #1: ____________________ Sister #1: __________________

Brother #2: ____________________ Sister #2: __________________

Brother #3: ____________________ Sister #3: __________________

Brother #4: ____________________ Sister #4: __________________

12. What do you hope to achieve with your doctor?

____
____
____
____

13. Emergency contact:

Name: __________________________ Relationship: ________________

Phone: _____________________ Mobile Phone:____________________

____
Print Name

____________________________________ ____________________
Signature Date

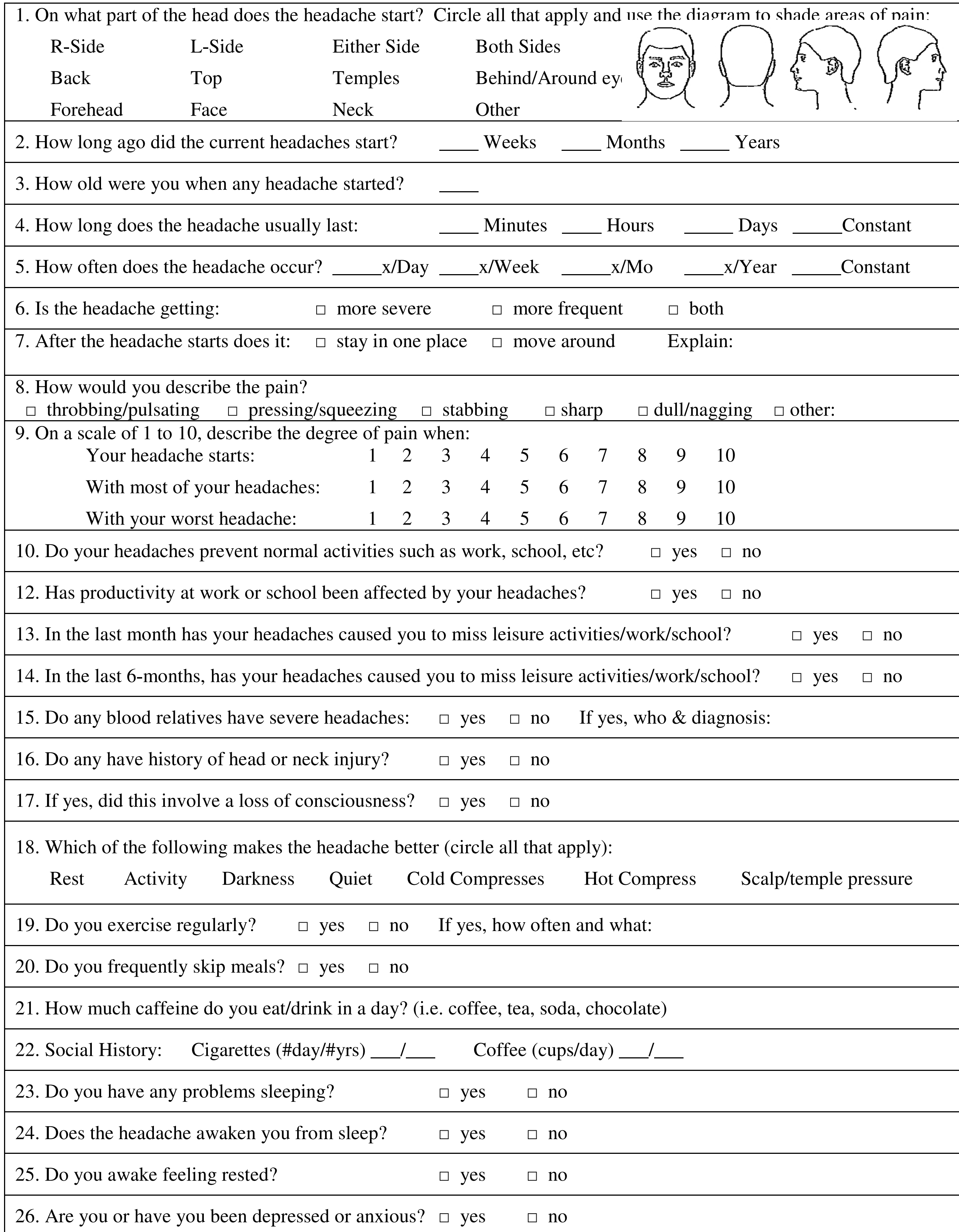
Tell Us How We're Doing!
Visit Our Website at www.dentinstitute.com and take our online survey

For office use only:

BP ______________ Pulse _______ Resp. ______ Wt. _____ Ht. _____

Headache History & Profile Questionnaire

Name: ______________________________ DOB: _______________ Date: _________________



1. On what part of the head does the headache start? Circle all that apply and use the diagram to shade areas of pain:

R-Side	L-Side	Either Side	Both Sides
Back	Top	Temples	Behind/Around ey
Forehead	Face	Neck	Other

2. How long ago did the current headaches start? ____ Weeks ____ Months _____ Years

3. How old were you when any headache started? ____

4. How long does the headache usually last: ____ Minutes ____ Hours _____ Days _____Constant

5. How often does the headache occur? _____x/Day ____x/Week _____x/Mo ____x/Year _____Constant

6. Is the headache getting: □ more severe □ more frequent □ both

7. After the headache starts does it: □ stay in one place □ move around Explain:

8. How would you describe the pain?
□ throbbing/pulsating □ pressing/squeezing □ stabbing □ sharp □ dull/nagging □ other:

9. On a scale of 1 to 10, describe the degree of pain when:

Your headache starts:	1	2	3	4	5	6	7	8	9	10
With most of your headaches:	1	2	3	4	5	6	7	8	9	10
With your worst headache:	1	2	3	4	5	6	7	8	9	10

10. Do your headaches prevent normal activities such as work, school, etc? □ yes □ no

12. Has productivity at work or school been affected by your headaches? □ yes □ no

13. In the last month has your headaches caused you to miss leisure activities/work/school? □ yes □ no

14. In the last 6-months, has your headaches caused you to miss leisure activities/work/school? □ yes □ no

15. Do any blood relatives have severe headaches: □ yes □ no If yes, who & diagnosis:

16. Do any have history of head or neck injury? □ yes □ no

17. If yes, did this involve a loss of consciousness? □ yes □ no

18. Which of the following makes the headache better (circle all that apply):
Rest Activity Darkness Quiet Cold Compresses Hot Compress Scalp/temple pressure

19. Do you exercise regularly? □ yes □ no If yes, how often and what:

20. Do you frequently skip meals? □ yes □ no

21. How much caffeine do you eat/drink in a day? (i.e. coffee, tea, soda, chocolate)

22. Social History: Cigarettes (#day/#yrs) ___/___ Coffee (cups/day) ___/___

23. Do you have any problems sleeping? □ yes □ no

24. Does the headache awaken you from sleep? □ yes □ no

25. Do you awake feeling rested? □ yes □ no

26. Are you or have you been depressed or anxious? □ yes □ no

Associated Headache Symptoms:

Are any of the following symptoms associated with the headache? Please mark: **(B) Before (X) During (A) After**

FACE AND SCALP:

____ Spots before eyes R/L
____ Blindness R/L
____ Blurring R/L
____ Eyelid Droop R/L
____ Tearing R/L
____ Double Vision R/L
____ Eye Redness R/L
____ Eyes Puffy R/L
____ See only half objects R/L
____ Noise Sensitivity
____ Odor Sensitivity
____ Light Sensitivity
____ Nose Discharge R/L
____ Nose Blocked R/L
____ Paleness
____ Redness
____ Sweating
____ Tenderness
____ Pain on chewing
____ Puffiness
____ Decreased jaw opening

PLEASE MARK IF YOU EXPERIENCE:
(W) Weakness (N) Numbness (B) Both

____ Face R/L
____ Arms R/L
____ Legs R/L
____ Arm and Leg R/L
____ Numbness around Lips

GENERAL:

____ Nausea
____ Vomiting
____ Stomach Cramps
____ Hunger
____ Loss of Appetite
____ Diarrhea
____ Depression
____ Fatigue
____ Anxiety
____ Irritability
____ Difficulty concentrating
____ Difficulty talking or finding words
____ Difficulty understanding
____ Fainting or feel like fainting
____ Slurred speech
____ Dizziness

NECK:

____ Stiffness
____ Tenderness

HANDS AND/OR FEET:

____ Cold
____ Pale
____ Sweaty
____ Mottled

Indicate if any of the following factors have **(+) Brought on** (trigger) or **(++) Worsened** your headache:

____ Sleep too much or little	____ Missed Meal	____ Cheese	____ Medications (list)
____ Emotional stress	____ Change in Weather	____ MSG	____ Menstrual Periods
____ Depression - anxiety	____ Seasons	____ Other foods (list)	____ Pregnancy
____ Physical Activity	____ Processed Meats	____ Straining/Coughing	____ Menopause
____ Erect Position	____ Chocolate	____ Menstrual Periods	____ Oral Contraceptives
____ Bending Over	____ Citrus Fruits	____ Oral Contraceptives	

Patient Name: ______________________________________

Chronic Migraine Screener

What is Chronic Migraine?
Chronic Migraine is a condition defined as 15 or more headache days a month with each headache lasting 4 hours or more per day. At least of half of the headaches should be migraine.
How to use this screener:
The following questions can help you and your physician understand your condition and help determine if you have Chronic Migraine. Being thorough about your headaches/migraines will help your physician determine how much of your headaches affect your daily life and help get you to a more accurate diagnosis and find treatment options that are right for you.

Personal Information

Name: ______________________________

Date of Birth: ___________________

Important information before you get started

What are headache days?
It is important to understand the number of days you had *headaches* (including migraines) rather than the number of *attacks.*

- For example, you have a headache that starts on Monday and does not go away until Wednesday; it may be one attack, but that is considered 3 *headache days*

Remember to provide your doctor with an accurate number of **ALL of the days you experience pain of any kind.**

Are migraine days the same as headache days?
Some of your headaches may be a type of headache known as *migraine*. If you experience any combination of the following symptoms, your headache may be a migraine:

- Constant, throbbing pain felt on one side of the head (but can be on both sides)
- Sensitivity to light and sound
- Nausea and/or vomiting
- Headaches that get worse with movement (you may want to lay down)

Whether your headache is a migraine or not, it still counts as a *headache day.*

What if the headache gets better or goes away after I take medication?
You should also count days that you treated/resolved your headache/migraine with either an over-the-counter medication like ibuprofen or prescription medication like sumatriptan. These days are still considered as days *with* headache

Please complete this to see if you may have Chronic Migraines

1(a) How many days in the past month did you spend with a headache/migraine?
(Include ALL days with any headache pain of any kind, even those you didn't feel you needed to take any medication for or only took an over-the-counter medication)

______ day(s)

1(b) How many days in the past month did you spend without ANY headache pain of any kind (headache-free days)?

______ day(s)

1(c) Subtract line B from 31 and enter the number:

______ day(s)

Regarding question 1 (a) or (c) was the answer 15 or more?

☐ Yes or ☐ No

2 Did any of your headaches/migraines last more than 4 hours, if you did not treat them?

☐ Yes or ☐ No

3 Have you ever been diagnosed as having chronic headaches (including tension-type or chronic sinus headaches)?

☐ Yes or ☐ No

4 Have you ever been diagnosed as having migraines?

☐ Yes or ☐ No

5 Do your headaches/migraines impact your daily life?

☐ Yes or ☐ No

Rate the impact of your headaches/migraines on your daily life:

1	2	3	4	5	6	7	8	9	10
Mild									Severe

How many days in the past month have your headaches/migraines severely affected your daily life?

______ day(s)

6 In the past month, did you take anything to treat your headaches/migraines?

☐ Yes or ☐ No

If "yes," how many days in the past month did you take something to treat your headaches/migraines (including over-the-counter drugs, prescription medication and/or vitamins/herbal remedies)?

______ day(s)

Please list what you have taken:

____

____

____

____

☐ Check here if you answered "Yes" to both questions 1 and 2 and at least one of the other questions.

Patient Name: ______________________________

Patient Name:_____________________________ **D.O.B:**__________ **Date:** _______________

DENT
NEUROLOGIC INSTITUTE

Adult MIDAS (18 years of age and older)

The MIDAS (migraine disability assessment) questionnaire was put together to help you measure the impact your headaches have on your life ***over the last 3 months*** and to communicate this more effectively. The best way to this is by counting the numbers of days of your life which are affected by Headaches.

INSTRUCTIONS • Please answers the following questions about ***ALL your headaches you have had over the last 3 months.*** Select your answer in the box next to each question. If a single headache affects more than one area of your life (e.g., work and family life) it is counted more than once. Select zero if you did not have the activity in the last 3 months. There are no "right" or "wrong" answers so please put down your best guess.

For questions 1 and 2, **work or school** means paid work or education if you are a student at school or college. For Questions 3 and 4, **household work** means activities such as housework, home repairs and maintenance, shopping as well as caring for children and relatives.

---

1. On how many days in the last 3 months did you miss work or school because your headaches?

☐

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches?
(Do not include days you counted in question 1 where you missed work or school.)

☐

3. On how many days in the last 3 months did you not do household work because of your headaches?

☐

4. How many days in the last three months was your productivity in household work reduced by half of more because of your headaches?
(Do not include days you counted in question 3 where you did not do household work.)

☐

Patient Name: ___________________________ **D.O.B:** _______________

5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

☐

Enter the total number of days you entered in questions 1-5. This is your MIDAS level of disability.

☐ **Total**

0 to 5 - MIDAS Grade I, *Little or no disability*

6 to 10 - MIDAS Grade II, *Mild disability*

11 to 20 - MIDAS Grade III, *Moderate disability*

21+ - MIDAS Grade IV, *Severe disability*

That Your Physician will need to know about your headache:

A. On how many days in the last 3 months did you have a headache?
(If a headache lasted more than 1 day, count each day.)

☐

B. On a scale of 0 - 10, on average how painful were these headaches?
(Where 0 = no pain at all and 10 = pain as bad as it can be.)

☐