



Consultants in Neurology, P.A.
Rowe Neurology Institute
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Welcome to the **Rowe Neurology Institute!** We are glad you've chosen to receive your neurologic care here. There are several things you should know about your visit with Dr. Rowe, and how this is different from a regular doctor's office:

The Rowe Neurology Institute and Dr. Rowe maintains a consultative, concierge neurology practice, seeing more complex patients in Kansas City and Los Angeles. Medicare and commercial insurance are **not** accepted. However, we can provide you with forms you can submit to your insurance carrier and any necessary ordered testing can be performed at facilities that are in network with your insurance.

Patients are seen by prepaid appointment only for a consultation fee. Call 913.647.4200 for details.

The Rowe Neurology Institute also focuses on Basic Research and Clinical Trials in the area of Multiple Sclerosis, Alzheimer's Disease and Dementia, Sleep Disorders, and Headache. Call 913.647.8000 for information on current clinical trials.

POLICIES:

NO TEST RESULTS ARE GIVEN OVER THE TELEPHONE. A visit with Dr. Rowe is the best and only way to discuss results and their importance.

MEDICATIONS REFILLS ARE HANDLED DURING OFFICE VISITS. No refills are handled after hours.

CALLS. If you think you are having a medical emergency, do not call our office. Call 911 or go to the emergency room.

Your office visit is your time to speak with Dr. Rowe. He will not be speaking with you by phone or email.

If you leave a message, we will make every attempt to return calls within 48 hours.

Do not request completion of FMLA paperwork. We do not complete FMLA or disability paperwork, please see your PCP.

Patient Responsibility Disclaimer and Authorization

I understand that Dr. Rowe /CONSULTANTS IN NEUROLOGY, P.A is not a Medicare Provider and is out of network with insurance companies, therefore I am responsible for payment of all charges. I have been given and have signed the "Medicare Private Contract form".

I understand that I am responsible to know which lab and outside facilities my insurance company utilizes for all lab work, diagnostic testing and specialist's appointments. If prior authorizations are required by my insurance contract for diagnostic testing and specialists' appointments, I realize that it is my responsibility to request a referral authorization. Failure to do so may result in my insurance company denying payment for services and I will be responsible for the services performed.

I also agree that in the event of collection, I agree to pay all outstanding charges, costs of collection including reasonable attorney's fees. I understand and agree to the financial policy as stated above.

Authorization for Medical Treatment and Access to Prescription History

While I am here, I permit the employees, the doctor, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician and staff will explain to me the nature of my condition and his recommended treatment and any associated risk involved. I also understand that this care may include diagnostic testing, examinations, medical and or/surgical treatment and no guarantees have been made to me about the outcome of this care. I also grant permission to access my prescription history across providers. This prescription History enables the doctor to make a more informed clinical decision.

Acknowledgement of Notice of Privacy Practices/Consent to Treat/Lab Result Notification/Photograph Consent

- I acknowledge that I have read the Notice of Privacy Practices. I understand that Dr. Rowe/Consultants in Neurology, PA. may, at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request.
- I give Dr. Rowe/CONSULTANTS IN NEUROLOGY, P.A permission to leave a message on my answering machine or with the following family members regarding reports, or blood work if I am not home when they call.
- I give Dr. Rowe/CONSULTANTS IN NEUROLOGY, P.A. permission to take my picture for identification purposes.
- I consent to general treatment, medical procedures, and medications prescribed by Dr. Rowe/CONSULTANTS IN NEUROLOGY, P.A.
- I understand the Dr. Rowe and staff of CONSULTANTS IN NEUROLOGY, P.A. will not discuss my health information with my family or friends unless I expressly authorize them to do so. Approved family members to leave my health care messages with:

- I consent to use email _____ and phone or texting (____)____-____to communicate with me regarding appointments, general treatment, medical procedures, and medications prescribed by Dr. Rowe/CONSULTANTS IN NEUROLOGY, P.A.

X _____ HIPAA Copy received by patient X _____ Patient declined copy (please initial)

I have read, understand and agree to all the policies as stated above.

Signature of Patient or Guarantor: X _____ Date: _____

Date: _____

ROWE NEUROLOGY INSTITUTE

CONSULTANTS IN NEUROLOGY, P.A.

****PLEASE PRINT LEGIBLY IN BLACK INK****PLEASE PRINT LEGIBLY IN BLACK INK****

PATIENT INFORMATION						Spouse (or Parent if Patient is minor)		
Last Name	First	MI				Last Name	First	MI
Date of Birth	Age	Male	Female					
SSN	M	S	D	W	DP	SSN		
Address						Address		
City	State	Zip						
Home Phone	Cell Phone					Home Phone	Cell Phone	
Employer	Work Phone					Employer	Work Phone	
Email Address								

EMERGENCY NOTIFICATION (Other than Spouse)

Name _____ Relationship _____ Phone _____

Is this a Workman's Compensation case ☐ Yes ☐ No
 Is this an automobile injury case ☐ Yes ☐ No
 Is this related to a specific injury ☐ Yes ☐ No If yes, please explain: _____

OTHER PHYSICIANS

Family Physician _____

Phone _____ Fax _____

Referring Physician _____

Phone _____ Fax _____

Date: _____

ROWE NEUROLOGY INSTITUTE

CONSULTANTS IN NEUROLOGY, P.A.

******PLEASE PRINT LEGIBLY IN BLACK INK****PLEASE PRINT LEGIBLY IN BLACK INK******

Name _____ Age: _____ Date of Birth _____ Sex: ☐ M ☐ F

What problem are you here to see the Doctor about: _____

Have you ever had any SURGERIES

Type	Date

MEDICINES YOU ARE NOW TAKING (Include "over the counter" medicines, vitamins and supplements)

Name	How much / How often	For what problem

PHARMACY INFORMATION

Name	Location	Telephone Number

ALLERGIES TO MEDICINE

☐ None Known

Name	Type of Reaction

ROWE NEUROLOGY INSTITUTE**CONSULTANTS IN NEUROLOGY, P.A.****MEDICAL PROBLEMS****Have you EVER had:****Checkmark all that you have had.**

- ☐ Seizures / Epilepsy
- ☐ Stroke
- ☐ TIA
- ☐ Multiple Sclerosis
- ☐ Headaches – Type _____
- ☐ Alzheimer's / Dementia
- ☐ Knocked out/head injury
- ☐ Parkinson's Disease
- ☐ Sleep Disorder – Type: Check Below
- ☐ Sleep Apnea ☐ Insomnia
- ☐ other: _____
- ☐ Neck Problems
- ☐ Low back problems
- ☐ Cancer - Type _____
- ☐ Non-cancerous tumor – Type _____
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Problem – Type _____
- ☐ Depression / Anxiety
- ☐ ADD or ADHD
- ☐ PTSD
- ☐ Other Psychiatric Disorder
- Type: _____
- ☐ Passing Out
- ☐ Arthritis
- ☐ Osteoporosis or Osteopenia
- ☐ Lung or Breathing Problem
- ☐ Asthma
- ☐ Other _____
- ☐ Tuberculosis (TB)
- ☐ Chicken Pox
- ☐ Shingles

YES

- ☐ Hepatitis ☐ B or ☐ C
- ☐ HIV / AIDS
- ☐ Lyme Disease
- ☐ Aneurysm
- ☐ Bleeding disorder
- ☐ Blood clot / Blood vessel disease
- ☐ Colon/Intestinal Disorder
- ☐ Acid Reflux / Heartburn
- ☐ Ulcers
- ☐ Thyroid disease
- ☐ Bladder Problem – Type _____
- ☐ Kidney Problem – Type _____
- ☐ Liver Disease
- ☐ Lupus
- ☐ Low Testosterone
- ☐ Total number of Pregnancies _____
- ☐ Number of Miscarriages _____
- ☐ Sexual Dysfunction
- ☐ Sexually Transmitted Disease
- Type: _____ ☐ Treated ☐ Untreated
- ☐ Anemia
- ☐ Iron deficiency
- ☐ B-12 deficiency
- ☐ Vitamin D deficiency
- ☐ Environmental Allergies / Hayfever
- ☐ Frequent infections
- ☐ Eye Glasses or Contact Lens (circle one)
- ☐ Fibromyalgia
- ☐ Hard of Hearing
- ☐ Use of Hearing Aid
- ☐ Dentures
- ☐ Alcoholism
- ☐ Drug Abuse

Are there any other medical conditions we need to know about?**Social History**

Occupation _____ Level of Education: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other: _____ # of Children: _____

Ethnicity/Race: _____

Handedness: ☐ Right ☐ Left ☐ Ambidextrous ☐ Mixed

ROWE NEUROLOGY INSTITUTE**CONSULTANTS IN NEUROLOGY, P.A.****PERSONAL HABITS (Checkmark all that apply)**

- ☐ **Yes** ☐ **No** Have you ever been a smoker? ☐ Current use ☐ Past Use
☐ Cigarettes ☐ Cigars ☐ Pipe Packs/day _____ How many years? _____
- ☐ **Yes** ☐ **No** Have you ever chewed tobacco How many years? _____
- ☐ **Yes** ☐ **No** Do you usually drink **caffeinated** coffee, tea, energy drinks and/or soda?
(Checkmark use per day) ☐ **OCCASIONAL (1-2)** ☐ **MODERATE (4-5)** ☐ **HEAVY (6-over)**
- ☐ **Yes** ☐ **No** Do you regularly drink **alcohol**? How many years? _____
(Checkmark use per week) ☐ **OCCASIONAL (1-2)** ☐ **MODERATE (4-5)** ☐ **HEAVY (6-over)**
- ☐ **Yes** ☐ **No** Do you or have you used recreational/street **drugs**? What and how long? _____
- ☐ **Yes** ☐ **No** Have you had extensive foreign **travel**? _____
- ☐ **Yes** ☐ **No** Have you had exposure to **toxins**? _____

FAMILY HISTORY	(Checkmark as appropriate) (other than yourself)	Comments
Stroke	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
TIA	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Brain Aneurysm	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Cancer	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Heart Attack	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Heart Disease	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Multiple Sclerosis	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Seizures	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Parkinson's Disease	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Tremor	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Migraines	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Headaches	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
High Blood Pressure	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Diabetes	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Polycystic Kidney Disease	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Lung Disease	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Depression	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Anxiety	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Alcohol or Drug Abuse	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Mental Illness	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Sleep Problems	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Senility or Dementia	☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter	
Are there any other medical conditions that run in your family? _____		
Father: ☐ Alive ☐ Deceased If deceased, age _____ and cause of death _____		
Mother: ☐ Alive ☐ Deceased If deceased, age _____ and cause of death _____		

ROWE NEUROLOGY INSTITUTE**CONSULTANTS IN NEUROLOGY, P.A.***Please check any that you've had in the last 3 months.***SLEEP**

- ☐ Problems going to sleep
- ☐ Problems staying asleep
- ☐ Snoring
- ☐ Excessive daytime sleepiness
- ☐ Falling asleep when you shouldn't
- ☐ Legs moving restlessly
- ☐ Sleep walking / talking
- ☐ Night Sweats

NEUROLOGIC Loss

- ☐ of smell Loss of
- ☐ taste Facial
- ☐ weakness
- ☐ Poor concentration
- ☐ Memory problems
- ☐ Difficulty walking
- ☐ Numbness
- ☐ Headaches
- ☐ Passing out
- ☐ Slurred speech
- ☐ Difficulty swallowing
- ☐ Lost ability to speak properly
- ☐ Lost ability to read properly
- ☐ Lost ability to write properly
- ☐ Unexplained spells
- ☐ Dizziness
- ☐ Tremors / shaking

EYES

- ☐ Blurred vision
- ☐ Color blindness
- ☐ Double vision
- ☐ Red eyes
- ☐ Inflammation
- ☐ Tearing
- ☐ Swollen eyelids
- ☐ Droopy eyelids
- ☐ Big pupils
- ☐ Small pupils
- ☐ Unequal pupils
- ☐ Worsened vision

EARS, NOSE, MOUTH, THROAT

- ☐ Deafness
- ☐ Ringing in ear
- ☐ Discharge from the ears
- ☐ Ear pain Mouth
- ☐ pain Dental
- ☐ problems
- ☐ Congestion

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Swelling in Hands
- ☐ Swelling in Feet
- ☐ Stiffness
- ☐ Weakness of muscles
- ☐ Muscle shrinkage
- ☐ Arm Pain
- ☐ Leg pain
- ☐ Low back pain
- ☐ Neck pain
- ☐ Thoracic pain (mid-back pain)

PSYCHIATRIC

- ☐ Irritability
- ☐ Depression
- ☐ Anxiety
- ☐ Bizarre behavior

ENDOCRINE

- ☐ Intolerance to heat or cold
- ☐ Excessive thirst
- ☐ Impotence
- ☐ Excessive facial hair
- ☐ Impossible to control blood pressure

CONSTITUTIONAL SYMPTOMS

- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue

CARDIOVASCULAR

- ☐ Palpitations
- ☐ Racing of the heart
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blue extremities
- ☐ Swollen extremities
- ☐ Cold extremities

RESPIRATORY

- ☐ Wheezing
- ☐ Dry cough
- ☐ Productive cough
- ☐ Coughing up blood
- ☐ Chest pain with breathing
- ☐ Shortness of Breath

GASTROINTESTINAL

- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Change in color of stool
- ☐ Hemorrhoids
- ☐ Blood in the stool
- ☐ Black tarry stools
- ☐ Incontinence of bowels
- ☐ Diarrhea
- ☐ Constipation

GENITOURINARY

- ☐ Urinary incontinence
- ☐ Blood in the urine
- ☐ Increased urinary frequency
- ☐ Up all night going to the bathroom
- ☐ Frequent urinary tract infections
- ☐ Going to the bathroom too often
- ☐ Change in color of urine

INTEGUMENTARY

- ☐ Change in skin color
- ☐ Stiffness
- ☐ Itching skin Dry
- ☐ skin Changes in
- ☐ hair Changes in
- ☐ nails Rash
- ☐ Sores
- ☐ Lumps
- ☐

HEMATOPOIETIC/LYMPHATIC

- ☐ Easy bleeding
- ☐ Swollen lymph nodes

The below scale is meant to measure how you feel about your health quality **today.**

Please place a line (|) on the scale where you believe your health quality is today, compared to your health in the past.

Overall health
is much worse

Overall health
is much better



THE EPWORTH SLEEPINESS SCALE

Patient Name: _____

Please use the following scale, to decide the likeliness you would doze off or fall asleep in the following situations.

Even if you have NOT done some of these things RECENTLY, try to answer how they would have affected you.

Using the following scale, please choose the most appropriate number for each situation:

- 0** = Would **NEVER** doze or fall asleep
- 1** = **Slight Chance** of dozing or falling asleep
- 2** = **Moderate Chance** of dozing or falling asleep
- 3** = **High Chance** of dozing or falling asleep

SITUATIONS:

Chance of dozing

Sitting and Reading

Watching TV

Sitting, inactive in a public place (Theatre, meeting, etc.)

As a passenger in a car, for an hour without a break

Lying down to rest in the afternoon

Sitting and talking to someone

Sitting quietly after lunch, without alcohol

In a car while stopped, for a few minutes in traffic

TOTAL :

Add up the numbers you put in each box to get your total score. A total score of less than 10 suggest that you may not be suffering from excessive daytime sleepiness. A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

Stop Bang Questionnaire

Name: _____ Age: _____ BMI: _____

Height: _____ Wt: _____ Neck Circumference: _____ in

Shirt Collar Size: ☐ Small ☐ Medium ☐ Large ☐ X-Large

Snooring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors?)

☐ YES ☐ NO

Tired: Do you often feel tired, fatigued or sleepy during the day?

☐ YES ☐ NO

Observed: Has anyone observed that you stop breathing during your sleep?

☐ YES ☐ NO

Blood **P**ressure: Do you have or are you being treated for high blood pressure?

☐ YES ☐ NO

BMI more than 35kg/m²? (If you're not sure ask the nurse)

☐ YES ☐ NO

Age over 50 years?

☐ YES ☐ NO

Neck circumference greater than 40 cm (15.75 in)?

☐ YES ☐ NO

Gender, male?

☐ YES ☐ NO

International Restless Leg Syndrome (IRLS) Symptoms Questionnaire

1. Do you have the desire to move your legs, often because of discomfort or restlessness?

(The need to move is often accompanied by uncomfortable sensations. Some words used to describe these sensations include: creeping, itching, pulling, creepy-crawly, tugging or gnawing.)

☐ YES ☐ NO ☐ Not Applicable

2. Does this desire occur or become worse when you are at rest, in other words, when you are sitting or lying down?

(The longer you are resting, the greater the chance the symptoms will occur and the more severe they are likely to be.)

☐ YES ☐ NO ☐ Not Applicable

3. Do you note any relief of symptoms completely or partly during activity?

(The relief can be complete or only partial but generally starts very soon after starting an activity. Relief persists as long as the motor activity continues.)

☐ YES ☐ NO ☐ Not Applicable

4. Do these symptoms occur or worsen only in the evening or at night?

(Activities that bother you at night do not bother you during the day)

☐ YES ☐ NO ☐ Not Applicable

Headache Patient Questionnaire

1. How many days a month do you have any kind of a headache?
2. How many days a month do you have a severe headache or migraine?
3. How old were you when you **first recall** having any kind of headache?
4. When you have a migraine / headache, how many hours do they last on average?
5. Has there been a **significant change** in your headaches recently? ☐ Yes ☐ No
If Yes, please describe below.
6. How **often** do you take headache **relievers or pain pills**?
7. Which medications have you **tried**: (circle all that apply) Advil, Aleve, Ibuprofen, Tylenol, etc.
8. Are your headaches sometimes accompanied by (checkmark all that apply):
 - ☐ Nausea
 - ☐ Vomiting
 - ☐ Sensitivity to light
 - ☐ Sensitivity to sound
 - ☐ Sensitivity to odor
9. Do these things ever happen when you have a headache (checkmark all that apply):

☐ Seeing zig-zag lines	☐ Losing vision to one side
☐ Having a blind spot	☐ Sensation of room spinning
☐ Things look too big or too small	☐ You pass out or come close to it
☐ You go numb on one side	☐ You get weak on one side
☐ Tearing of one eye	☐ One drooping eyelid
☐ Running or stuffiness one nostril	☐ Redness / Swelling one eye

10. Is your headache pain sometimes (checkmark all that apply):

- | | |
|--|------------------------------------|
| ☐ Made worse with movement/activity | ☐ One-sided |
| ☐ Pounding | ☐ |
| ☐ Stabbing | |
| ☐ Throbbing | ☐ |
| ☐ Pressure | |

11. Do you have any of the following with your headaches? (checkmark all that apply):

- | | |
|---------------------------------------|--------------------------|
| ☐ Ringing ears | ☐ |
| ☐ Tender scalp | |
| ☐ Neck pain | |

12. Is your headache onset after **strenuous physical exercise or sex**?

- ☐ Yes
☐ No

13. Are your headaches **produced** (not just worsened) by **straining**, such as with a bowel movement?

- ☐ Yes
☐ No

14. Have your headaches had a recent **change in pattern**?

- ☐ Yes
☐ No

15. Have your headaches **worsened** over the past 4 weeks **despite medications** that previously worked?

- ☐ Yes
☐ No

16. Do your headaches occur with a **sudden onset**?

- ☐ Yes
☐ No

17. Do you have a history of **head trauma** within the past year?

- ☐ Yes
☐ No

18. Do your headaches **frequently awaken** you at night?

- ☐ Yes
☐ No

19. Do you **wake up** with a headache? ☐ Yes ☐ No