To complete questionnaire - please check the box or fill in the blanks with the best answer.

Patient History

Name: Date:

Birth date: Age: ☐ male ☐ female

Referring physician: Primary Physician:

Reason for visit:

Past treatment: ☐ headache clinic ☐ pain management center ☐ none

Location of clinic or center:

Past testing: ☐ MRI ☐ MRA ☐CT scan ☐ EEG ☐ Sleep study ☐ Lab tests

Where were these completed?

PLEASE BRING ALL REPORTS OF TREATMENT OR TESTING WITH YOU TO THE FIRST VISIT.

Headache History

Do you have more that one headache type: ☐ Yes ☐ No

If yes, briefly describe the different headaches here:

First headache type:

Second headache type:

Are you ever HEADACHE FREE? ☐ Yes ☐ No When?

Onset of first headache: started years ago I was _____ years old

Precipitating event (what provoked your **first** headache?)

☐ none known ☐menarche (first period) ☐injury:

☐ pregnancy ☐other:

Current pattern: ☐ sudden ☐ rapid ☐ gradual ☐ varies

Time of Day: ☐morning ☐afternoon ☐evening ☐night ☐awaken from sleep ☐varies

Frequency (number of attacks): *Fill in the number*

_____per day _____per week _____per month _____per year

☐ continuous ☐ lifetime attacks

Are they increasing in frequency? ☐ Yes ☐ No

Duration (how long do they last?) *Fill in the number*

with medication _____minutes _____hours _____days

without medication _____minutes _____hours _____days

How often do they recur within 24 hours - *with* medication *without* medication

Provoking factors (things that bring on a headache)

Food/beverage: ☐fasting ☐ chocolate ☐ caffeine ☐ nitrates

☐MSG ☐ alcoholic beverages -what ones in particular?

☐other:

Physical exertion: ☐ coughing ☐ talking ☐ chewing ☐ exercise

☐ sexual intercourse

Hormonal: Menses - ☐ before ☐ during ☐ after

☐ pregnancy ☐ menopause

Stress: ☐ work ☐ home ☐ family ☐ spouse

☐ other:

Environmental: ☐ allergies ☐ weather changes ☐ altitude ☐ sunlight

☐ other:

Sleep: ☐ lack of sleep ☐ too much sleep ☐ change in wake/sleep

How many hours of sleep do you average? ☐ 1-3 ☐ 3-5 ☐ 5-7 ☐ 7-8 ☐ 8-10

Other triggers: _____

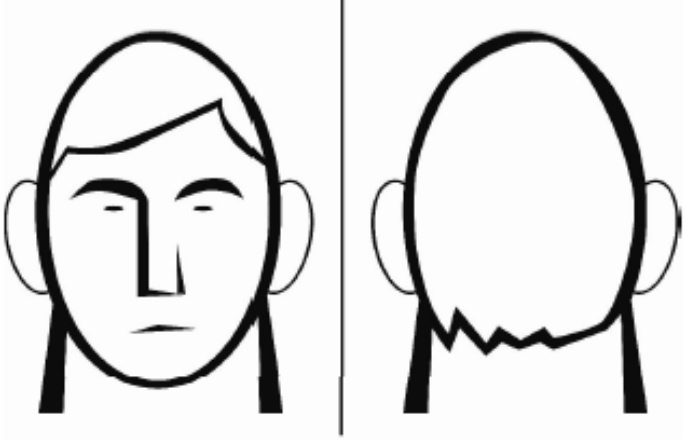
What makes your headache worse? _____

How do your headaches affect your ability to function? Write in the number of days missed.

work productivity _____ days/month missed
school _____ days/month missed
social/family activities _____ days/month missed

Severity - how bad is the pain on a scale of 0-10 where 0 is no pain and 10 is the most unbearable

today 0☐--1☐--2☐--3☐--4☐--5☐--6☐--7☐--8☐--9☐--10☐ (Check the number)
best day 0☐--1☐--2☐--3☐--4☐--5☐--6☐--7☐--8☐--9☐--10☐
worst day 0☐--1☐--2☐--3☐--4☐--5☐--6☐--7☐--8☐--9☐--10☐



Please place an X on the drawing to show the location(s) of your pain.

Right *Left* *Left* *Right*

What symptoms do you experience with your headache?

☐ nausea ☐diarrhea ☐vomiting ☐ sensitivity to sound
☐ dizziness ☐stuffy/runny nose ☐red/teary eyes ☐ sensitivity to light
☐ vision change ☐numbness/tingling ☐ringing in the ears ☐ sensitivity to smell
☐ anorexia (loss of appetite)

Check any of the following that you have used to reduce the frequency of and duration of your headache:

☐ biofeedback ☐acupuncture ☐occipital blocks ☐TENS ☐herbal remedies
☐ exercise ☐counseling ☐heat ☐ice ☐massage therapy
☐ stress management ☐relaxation techniques
☐ chiropractic treatments ☐pain management center
☐ cervical epidural injections ☐alternative medicine clinic

Do you have allergies to: ☐ dyes ☐ iodine ☐ tyramine ☐ latex

Do you experience fatigue or a drained feeling following the resolution of your headache? ☐ Yes ☐ No

Social History

☐ single ☐ married ☐ widowed ☐ divorced ☐ separated
If married, fill in your spouse's age:_____ occupation:_____
Spouse's general health status:

Who resides in your home? ☐ live alone ☐ children at home
live with:

Do you smoke? ☐ Yes ☐ No ☐ Never smoked ☐ Second hand smoke

Do you consume alcohol? ☐Yes ☐ No
If yes, what type and how often?

Do you use illicit or recreational drugs? ☐ Yes ☐ No
If yes, what kind how often?

Have you ever had a problem with drug or alcohol abuse? ☐ Yes ☐ No

1. Do you have pain or tightness in your neck and shoulders with your headaches?

- Yes
- No

2. Is your pain constant and steady?

- Yes
- No

3. Does your headache feel like your head is being squeezed?

- Yes
- No

4. Do you usually have one or more headaches per week?

- Yes
- No

5. Does any blood relative have similar headaches? (Mother, father, sister, brother, etc.)

- Yes
- No

6. Does your headache pound, pulsate or throb?

- Yes
- No

7. Is your headache usually only on one side of your head or the other?

- Yes
- No

8. Do you have any visual changes such as seeing lines or spots?

- Yes
- No

9. When you have a headache, are you sensitive to bright lights and noise?

- Yes
- No

10. Do any of the following foods or drinks aggravate your headaches: chocolate, caffeine, alcohol, cheese, milk, nuts, or Chinese food?

- Yes
- No

11. During your headaches do you experience nausea or vomiting?

- Yes
- No

12. Does physical activity aggravate your headaches?

- Yes
- No

13. Are your headaches so intense that they prevent you from participating in normal activity?

- Yes
- No

14. Do your headaches last less than three hours?

- Yes
- No

15. Do you have severe facial or eye pain on one side of your head with your headaches?

- Yes
- No

16. Do your headaches tend to come for daily for several weeks then disappear for weeks or months?

- Yes
- No

17. Do you wake up 1-3 hours after falling asleep with a headache?

- Yes
- No

18. Do you experience a severe headache after stopping your headache medication?

- Yes
- No

19. Do you have nasal congestion and pain in your face, jaws, or forehead with your headaches?

- Yes
- No

20. Do your headaches get worse after eating or chewing?

- Yes
- No