Headache Intake Assessment Form

Name: _____Date:_____

Age: _____ Sex: M F Marital Status _____

Name of Spouse: _____

Name(s) and Age(s) of children:_____

_____

Names & Types of Pets: _____

Education: _____

Occupation: _____ Spouse's occupation:_____

Does anyone in your family have headaches, or have they had moderate-to-severe headaches in the past? _____

How old were you when you started having headaches? _____

How often do you have a mild -moderate headache? _____

How often do you have a severe headache/ migraine? _____

How long do the severe headaches last? __hours __one day __ two days __three or more days

On a scale of one to ten, ten being the worst, how severe are the headaches?

1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Do you have some type of headache every day? _____

How much do these daily headaches bother you? Mildly _____ Moderately _____ Severely ____

Where does the pain occur for your daily headaches? _____

Where does the pain occur for your severe headaches/migraines?_____

What does your headache typically feel like? (please circle one)

Throbbing/pulsing *Pressing/squeezing* *sharp/stabbing* *dull/achy*

Does your eye tear on the side of the headache?	Yes	No
Are the headaches much worse in the last few months?	Yes	No
Are the headaches much worse in the last year?	Yes	No
Do you frequently have nausea with your headaches?	Yes	No
Do you typically have visual problems with your headaches; such as flashing lights, sprinkles of light, or vision loss on one side?	Yes	No
Do you typically experience sensitivity to light?	Yes	No
Do you typically experience sensitivity to sound?	Yes	No
Are your headaches worse before or during your menstrual cycle?	Yes	No

Do you take any birth control pill or hormone? _____

Circle the following if these play a role in your headaches or in producing an occasional headache:

stress
after stress is over
weather changes
foods
bright sunlight
sexual activity
under sleeping
oversleeping
hormonal changes
menstrual cycle

exercise
exertion
missing a meal
cigarette odor
perfume odors
different seasons:
summer
fall
winter
spring

Do you have very cold feet and hands in the winter? _____

Have you had any of the following tests?

CT scan for your headaches? Y or N If so, when? _____Results _____

MRI for the headaches? Y or N If so, when? _____ Results_____

Blood tests in the past year? _____ Were they normal?_____

Have you tried Biofeedback or relaxation training for headaches? Yes No

If yes, has it helped? _____

_____

How much do you exercise, and what do you do? _____

_____

Which doctors have you seen for headaches, if any? _____

_____

_____

_____

Which family doctors or other doctors do you see? _____

_____

_____

_____

Do you smoke cigarettes? Yes No *If yes*, how many_____

Do you drink alcohol? Never Occasionally Daily

Have you had any type of problem with addictive drugs in the past? _____

Do you tend to be anxious or nervous? Yes No

If yes, is your anxiety mild, moderate, or Severe? _____

Do you have trouble Sleeping? Y N If yes, do you have trouble going to sleep? Or staying asleep? _____

Do you have a history of depression? Y or N If yes, when was your last episode? _____

Is/was it: Mild Moderate or Severe

Other past medical history:

Operations? _____

_____

Ulcers or stomach problems? _____

_____

Asthma? _____

_____

Any other medical problems? _____

_____

_____

_____

Side effects or allergies to any medications? _____

_____

_____

What medications are you **currently** taking? _____

_____

_____

_____

_____

_____

_____

_____