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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name: | | |  | | | | | | | | | | | | | | | | | | | |  | | Date: | | |  |
|  | | |  | | | | | | |  | | | | | | | | |  | | | | | |  | | |  |
| **Headache Assessment** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| When did your current headache problem begin? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | □ months □ years | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have your headaches changed in the last six months? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | □ About the same | | | | | | □ Slight worsening | | | | | | | | | | | | | | | □ Same but more frequent | | | | | | |
|  | □ A lot worse | | | | | | □ New type of headache | | | | | | | | | | | | | | | | | | | | | |
|  | □ Got worse when | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Where are your headaches located? *(Mark Locations)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | On a scale of 1-10, how painful are your headaches/migraines? | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ Yes □ No | | | | Did you suffer from headaches when you were younger? If so, | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | □ As a child | | | | | | | | | | | | □ In your 20s – 40s | | | | | | | | | | | | |
|  | | | | □ As a teenager | | | | | | | | | | | | □ In your 50s – 60s | | | | | | | | | | | | |
|  | | | | When were your headaches at their worst? | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| □ Yes □ No | | | | Was there a specific event that caused your current headache problem? | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | □ None/Unknown | | | | | | | | | | | | |  | | | | | | | | | | | |
|  | | | | □ First period | | | | | | | | | | | | | □ Pregnancy | | | | | | | | | | | |
|  | | | | □ Birth Control Pills | | | | | | | | | | | | | □ Hormone Replacement | | | | | | | | | | | |
|  | | | | □ Specific event | | | | | | | | | |  | | | | | | | | | | | | | | |
|  | | | | □ Injury | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | □ Car accident | | | | | | | | |  | | | | | | | | | | | | | | | |
|  | | | | □ Illness | | | |  | | | | | | | | | | | | | | | | | | | | |
|  | | | | □ Other | | | |  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How often do you get severe headaches/migraines that make it difficult to function without treatment or medication? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | □ Occasionally | | | | | | | | | | □ More than once a month | | | | | | | | | | | | | | | | | |
|  | □ More than twice a year | | | | | | | | | | □ More than once a week | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How often do you get other milder headaches? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | □ Daily | | | | | | | | | | □ More than 2 per month | | | | | | | | | | | | | | | | | |
|  | □ More than 3 per week | | | | | | | | | | □ Other | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ Yes □ No | | | | Are your headaches increasing in frequency? If so, describe frequency | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | □ Weekdays | | | | | | | | □ Spring | | | | | | | | | □ Fall | | | | | | | |
|  | | | | □ Weekends | | | | | | | | □ Summer | | | | | | | | | □ Winter | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Headaches typically begin, | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | □ Gradually | | | | □ Suddenly | | | | | | | | | | □ Varies | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Headaches usually being in the | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | □ Morning | | | | □ Afternoon | | | | | | | | | | □ Evening | | | | | | | | | □ Night | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How long before they reach their maximum intensity? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | □ minutes □ hours | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How bad are your headaches? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | With medication | | | | | □ Mild □ Moderate □ Severe □ Incapacitating | | | | | | | | | | | | | | | | | | | | | | |
|  | Without medication | | | | | □ Mild □ Moderate □ Severe □ Incapacitating | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Headaches prevent activities such as | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | □ School □ Work □ Household Chores □ Other | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What does your headache pain typically feel like? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | □ Pressure □ Stabbing □ Throbbing □ Tight Band | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | □ Burning □ Dull Ache □ Other | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Do any of the following bring on/trigger your headaches? | | | | | | | | | | | | | | | | |
|  | □ Specific food triggers. If so, please see next question for specifics. | | | | | | | | | | | | | | | |
|  | □ Too much caffeine | | | | | | | □ Not getting enough caffeine | | | | | | | | |
|  | □ Fatigue | | | | | | | □ Too little sleep | | | | □ Too much sleep *(sleeping in)* | | | | |
|  | □ During stressful times | | | | | | | □ After stress *(first day of vacation, weekend, after a test)* | | | | | | | | |
|  | □ Menstruation | | | | | | | □ Sexual Activity | | | | □ Coughing | | | | |
|  | □ Weather changes | | | | | | | □ Prolong computer work | | | | | | | | |
|  | □ Certain odors | | | | | | | □ Loud sounds | | | | □ Bright lights/sun | | | | |
|  | □ Other | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| If you are aware of food triggers, please list your trigger foods below. | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| How did you become aware of your triggers? *(Please check all that apply and provide detail if necessary)* | | | | | | | | | | | | | | | | |
|  | □ Observation/instinct | | | |  | | | | | | | | | | | |
|  | □ Trial and error | | |  | | | | | | | | | | | | |
|  | □ By completing food/symptom diaries | | | | | | | | |  | | | | | | |
|  | □ Suggestion from MD, dietician, naturopath | | | | | | | | | |  | | | | | |
|  | □ Other | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Do you experience any of the following before your headache begins? | | | | | | | | | | | | | | | | |
|  | □ Mood changes | | | | | | | □ Personality changes | | | | | □ Change in appetite | | | |
|  | □ Food Cravings | | | | | | | □ Neck Pain | | | | | □ Fatigue | | | |
|  | □ Other | | | | | | |  | | | | | | | | |
|  | □ No, I don’t experience any of these | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Do you experience any of these symptoms during your headaches? | | | | | | | | | | | | | | | | |
|  | □ Nausea/upset stomach | | | | | | | | □ Vomiting | | | | | | □ Numbness or tingling | |
|  | □ Lightheadedness | | | | | | | | □ Dizziness | | | | | | □ Vertigo | |
|  | □ Difficulty concentrating | | | | | | | | □ Mood changes | | | | | | □ Irritability | |
|  | □ Teary eyes | | | | | | | | □ Runny or stuffy nose | | | | | | | |
|  | □ Loud sounds bother you | | | | | | | | □ Strong smells/odors bother you | | | | | | | |
|  | □ Bright lights/sun bothers you | | | | | | | |  | | | | |  | | |
|  | □ Increased sensitivity of | | | | | | | | □ Scalp □ Hair □ Ears | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| What other doctors have you seen or tests have you had for your pain headaches, and/or migraines | | | | | | | | | | | | | | | | |
|  | □ Family Doctor | | | | | | □ Oral/Maxillofacial Specialist | | | | | | | | |  |
|  | □ Dentist (if other) | | | | | | □ Psychiatrist/Psychologist | | | | | | | | | |
|  | □ Physical Therapist | | | | | | □ MRI/CT Scan/Blood Work | | | | | | | | | |
|  | □ Chiropractor | | | | | | □ Other | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | |
| What medications are you currently taking to alleviate your headaches? | | | | | | | | | | | | | | | | |
|  |  | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| What medications or therapies have you previously tried to alleviate your headaches? | | | | | | | | | | | | | | | | |
|  |  | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| □ Yes □ No | | | Do you try non-medicating techniques for managing your headaches? | | | | | | | | | | | | | |
|  | □ Breathing Exercises | | | | | □ Yoga | | | | | | □ Cold Packs | | | | |
|  | □ Physical Therapy | | | | | □ Medication | | | | | | □ Massage | | | | |
|  | □ Other |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |