|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 |  |
|  |  |

|  |
| --- |
| 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  |  |
|  |