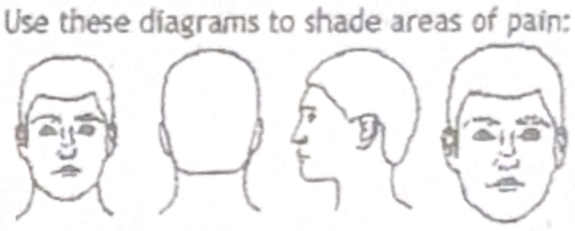
* Print Name: _____ * Date of Birth: _____ / _____ / _____

- On what part of the head do the headaches start?

  ❑ right side ❑ left side ❑ either side ❑ both sides
  ❑ back ❑ on top ❑ temples ❑ behind/around eyes
  ❑ forehead ❑ face ❑ neck ❑ other _____

Use these diagrams to shade areas of pain:



- How long ago did the current headaches start? _____ weeks _____ months _____ years
- How old were you when any headache started? _____
- How long does the headache usually last? ____ minutes ____ hours ____ days ❑ constant
- How often does the headache occur? ____ x/day ____ x/week ____ x/month ____ x/year ❑ constant
- Does the headache awaken you from sleep ❑ yes ❑ no
- Is the headache getting: ❑ more severe ❑ more frequent ❑ both
- After the headache starts, does it usually: ❑ stay in one place ❑ move around explain _____

_____

- Describe the pain: ❑ throbbing/pulsating ❑ pressing/squeezing ❑ stabbing ❑ sharp ❑ dull/nagging ❑ exploding
  ❑ other (explain) _____

SLIGHT < 1 2 3 4 5 6 7 8 9 10 > WORST IMAGINABLE

- Circle degree of pain *when headaches start:* < 1 2 3 4 5 6 7 8 9 10 >
- Circle degree of pain with *most of your headaches:* < 1 2 3 4 5 6 7 8 9 10 >
- Circle degree of pain with *your worst headache*: < 1 2 3 4 5 6 7 8 9 10 >
- Do any blood relatives have severe headaches? ❑ yes ❑ no

  If yes, who/diagnosis _____

- Do you have any history of head or neck injury? ❑ yes ❑ No

  If yes, did injury involve a loss of consciousness? ❑ yes ❑ no

- Which of the following makes the headache better? ❑ rest ❑ activity ❑ darkness ❑ quiet ❑ hot compress
  ❑ pregnancy ❑ menopause ❑ cold compress ❑ scalp or temple pressure

YOUR LIFESTYLE

- Are you: ❑ single ❑ married ❑ separated ❑ divorced ❑ widowed
- Do you exercise regularly? ❑ yes ❑ no If yes, what exercise/how often? _____
- Do you regularly skip meals? ❑ yes ❑ no
- How much caffeine do you consume in a day? (coffee, tea, soda, chocolate, etc) _____
- Cigarettes - # days _____/# years _____; Alcohol - oz/day _____
- Do you have any problems sleeping? ❑ yes ❑ no
- Do you wake feeling rested? ❑ yes ❑ no
- Other drug use: ❑ yes ❑ no
- Are you exposed to: ❑ fumes ❑ dust ❑ solvents ❑ airborne particles

Associated Headache Symptoms

■ Are any of the following symptoms associated with the headache?
Indicate by marking *B* (before), *X* (during), or *A* (after)

__ Spots before eyes - type
__ blindness (R) (L)
__ blurring (R) (L)
__ eyelid droop (R) (L)
__ can see only half of objects
__ tearing (R) (L)
__ double vision
__ eye redness (R) (L)
__ eyes puffy (R) (L)
__ light sensitivity
__ noise sensitivity
__ odor sensitivity
__ nose blocked/discharge (R) (L)

__ nausea
__ vomiting
__ stomach cramps
__ hunger
__ loss of apetite
__ diarrhea

Face/scalp

__ pale
__ redness
__ sweating
__ tender
__ pain on chewing
__ puffy
__ decreased jaw opening

Neck

__ stiff
__ tender

__ depression
__ fatigue
__ anxiety
__ irritability
__ dificulty concentrating
__ difficulty understanding
__ difficulty talking *(finding words)*
__ fainting *(feel like or have fainted)*
__ slurred speach
__ dizzy *(lightheaded • unsteady • spinning)*

Hands and/or feet

__ cold
__ pale
__ sweaty
__ mottled

Weakness (W); numbness (N); both (B)

__ face (R) (L)
__ arms (R) (L)
__ legs (R) (L)
__ arm & leg (R) (L)
__ numbness around lips

■ Indicate if any of the following factors *BROUGHT ON/TRIGGERED* (+) or *WORSENED* (++) your headache

__ sleep; too much/too little
__ sexual activity
__ chocolate
__ medications *(list below)*
__ emotional stress; during/after
__ missed meal
__ citrus fruits
__ menstrual period
__ depression/anxiety
__ change in weather
__ cheeses
__ pregnancy
__ physical activity
__ seasons
__ MSG
__ menopause
__ erect position
__ alcohol
__ other foods *(list below)*
__ oral contraceptives
__ bending over
__ processed meats
__ straining/coughing

list foods or medications if indicated above: _____

_____

_____