MOVEMENT CLINIC

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Headache History

Name: ____   Date: ______________________

Onset

When did your most recent headache begin? ____

What time of day do you typically first notice your headache?

☐ Awakens from sleep   ☐ When I first wake up   ☐ Later in the day   ☐ Varies   ☐ Other: __________________

When was the first time you ever had a headache? ______________________________________

Location

Describe the location of your headaches as accurately as possible.

____

____

____

Do your headaches always involve the same location? Yes ☐ No ☐

Do your headaches change sides? Yes ☐ No ☐

Frequency

How often do you have headaches?

______ /Day   ______ /Week   ______ /Month   ______ /Year

Are your headaches:

☐ More frequent   **OR**   ☐ Less frequent now than they used to be

Do your headaches:

☐ Come and go in cycles   **OR**   ☐ Are they about the same month to month

Duration

How long do your headaches typically last?

☐ Hours   ☐ Days   ☐ Weeks   ☐ Constant

Family History

Has anyone else in your family had headaches? ☐ Yes ☐ No

If yes, who? ____

Past Medical History and Systems Review

Have you ever had any conditions, injuries, or issues related to the following:

High Blood Pressure	☐ Past ☐ Present	Stroke	☐ Past ☐ Present
Diabetes	☐ Past ☐ Present	Sinuses	☐ Past ☐ Present
Head	☐ Past ☐ Present	Jaw	☐ Past ☐ Present
Teeth	☐ Past ☐ Present	Ear(s)	☐ Past ☐ Present
Neck	☐ Past ☐ Present		

Previous Testing

Have you had any examinations or testing for your headaches? Please include approximate date if possible.

☐ Physical examination ______________________

☐ Neurologic evaluation ______________________

☐ X-rays ______________________

☐ CT or MRI ______________________

☐ Eye exam ______________________

☐ Other tests: ____

Medication History/Use

Please list all medications that you take either by prescription or on your own to treat your headaches.

____

____

Females – Menstrual and Obstetric Factors

Did your headaches begin at about the same age that you began your menstrual cycle? ☐ Yes ☐ No

Did your headaches begin during a pregnancy? ☐ Yes ☐ No

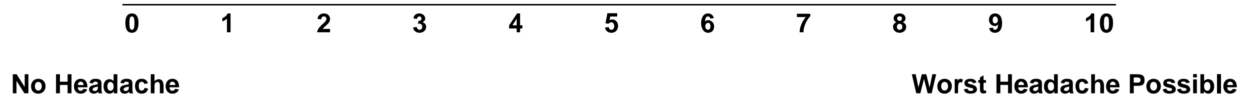
Did your headaches stop during a pregnancy? ☐ Yes ☐ No

Have your headaches changed with or are they associated with:

☐ Menopause ☐ Estrogen therapy ☐ Birth control pills

Severity

Indicate on the line below at the point that best represents the intensity of your headache at its **WORST** and **BEST**.



No Headache **Worst Headache Possible**

Has the severity of your pain: ☐ Increased recently **OR** ☐ Stayed the same

Are your headaches the same now as they have always been? ☐ Yes ☐ No

If they are different, what has changed? ____

Prodromal Signs/Symptoms

Do you have any of the following occur before or in the beginning of a headache?

☐ Zigzags in your vision

☐ Flashing lights

☐ Loss of part of your vision

☐ Objects look abnormal in size or shape

☐ Numbness or tingling

☐ Abnormal sense of smell

Associated Symptoms

Do you ever experience?

☐ Sensitivity to light or sounds

☐ Nausea or vomiting

☐ Imbalance or clumsiness standing or walking

☐ Double vision

☐ Ringing in your ears

☐ Seizures or loss of consciousness

Precipitating Factors

Are your headaches ever brought on by?

☐ Fatigue or loss of sleep
☐ Stress
☐ Menstruation Cycle

☐ Bright light
☐ Certain foods or drugs
☐ Alcohol

☐ Hunger
☐ Other: ______________________________

George's Cerebrovascular Craniocervical Function Test

Please check the correct response.

Have you ever been diagnosed or told you have any of the following?

High blood pressure (Hypertension) ☐ Yes ☐ No
Hardening of the arteries (Atherosclerosis) ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Heart or Blood Vessel Disease ☐ Yes ☐ No
Bone spurs on the neck bones (cervical spondylosis) ☐ Yes ☐ No
Whiplash injury (flexion-extension injury) (cervical spine) ☐ Yes ☐ No
Have any of your relatives suffered a stroke? ☐ Yes ☐ No
Do you take any medications on a regular basis? ☐ Yes ☐ No
Were you ever a smoker? ☐ Yes ☐ No
    If yes, from ____________ to ____________
Have you ever taken oral contraceptives? ☐ Yes ☐ No
    If yes, from ____________ to ____________

Have you had any of the following, even short, temporary attacks in the last year?

Blurred vision ☐ Yes ☐ No
Double vision ☐ Yes ☐ No
Diminished or partial loss of vision in one or both eyes? ☐ Yes ☐ No
Complete loss of vision in one or both eyes? ☐ Yes ☐ No
Ringing, buzzing or any noise in the ear(s)? ☐ Yes ☐ No
Hearing loss in one or both ears? ☐ Yes ☐ No
Slurred speech or other speech problems? ☐ Yes ☐ No
Difficulty swallowing? ☐ Yes ☐ No
Dizziness? ☐ Yes ☐ No
Temporary lack of understanding? ☐ Yes ☐ No
Loss of consciousness, even momentary blackouts? ☐ Yes ☐ No
Numbness or loss of sensation in face, fingers, hands,
arms, legs or any other part of the body? ☐ Yes ☐ No
Any other abnormal sensations in any part of your body? ☐ Yes ☐ No
Weakness, clumsiness, or loss of strength in your
fingers, face, hands, arms or legs? ☐ Yes ☐ No
Sudden collapse without loss of consciousness? ☐ Yes ☐ No

Signature: ____ **Date:** ______________________