Headache Intake Assessment Form

Name: ______________________________ Date: ____________________

Age ___________ Sex: M F

Ages of Children: ________________ Types of pets: ____________________

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?

___ As a child ___ As a teenager ___ in my 20's-40's ___ in my 50's or 60's

Was there a precipitating event or trigger for your current headache problem?

___ None known ___ Specific stress ___ Injury
___ Motor vehicle accident ___ Illness ___ Menarche (first period)
___ Pregnancy ___ Birth control pill ___ Hormone replacement
___ Other ___________________________

Frequency of headaches: on average, how often do you have headaches?

They occur ___ times each ___ day ___ week ___ month
Are they increasing in frequency? Yes No
They are more frequent on :
___ Weekdays ___ Weekends
___ Spring ___ Summer ___ Fall ___ Winter

Onset of each headache:

Headaches typically begin: ___ gradually ___ suddenly ___ varies
They usually begin in the: ___ Morning ___ Afternoon ___ Evening ___Night
How long before they reach maximal intensity? ___ Minutes ___ Hours

Duration of headaches:

Headaches usually last (with medication) ___ Minutes ___ Hours ___ Days
Headaches usually last (without medication)___ Minutes ___ Hours ___ Days

Intensity of the headaches: *How bad are your headaches?*

With medication: ___ Mild ___ Moderate ___ Severe ___ Incapacitating
Without medication: ___ Mild ___ Moderate ___ Severe ___ Incapacitating
Headaches prevent activities: ___ School ___ Work ___ Household chores

Location of headaches: *Where do you feel the pain during your headaches?*

___ Left side ___ right side ___ may be either side ___ Both sides ___ other
___ forehead ___ temple ___ behind eyes ___ back of head ___ neck

Pain Type: *What does the headache pain feel like?*

___ Pressure ___ Stabbing ___ Throbbing ___ Other ______________
___ Tight band ___ Burning ___Dull ache

Headache Triggers: *Do any of the following bring on/trigger your headaches?*

___ Foods ___ Too much caffeine ___ Not getting enough caffeine
___ Hunger/skipping meals ___ Alcohol ___Wine
___Fatigue ___ Too little Sleep ___ Too much sleep
___ During stress ___ After stress (first day of vacation, weekend, after a test)
___ Menstruation ___ Exercise ___ Sexual activity

___ Coughing ___ Prolonged computer use ___ Weather changes
___ Certain odors ___ Bright lights/sun ___ Loud sounds
Other ______________________________

Premonitory Symptoms: *Do you experience any of the following **before** your headache begins?*
___ Mood changes ___ Personality changes Other ________________
___ Food cravings ___ Change in appetite ___ None
___ Neck pain ___ Fatigue

Aura Symptoms: *Do you ever experience any of these warning symptoms **before** your headache begins?*
___ Zig-zag lines ___ Partial loss of vision/blurry vision/blindness (circle applicable)
___ Paralysis ___ Bright lights/flashes of light/multicolored lights (circle applicable)
___ Dizziness/vertigo ___ Numbness/tingling
___ Upset stomach ___ Nausea ___ None

Associated symptoms: *Do you experience any of these symptoms **during** your headaches?*
___ Nausea/Upset stomach ___ Vomiting
___ Bright lights/sun bothers you ___ Loud sounds bother you
___ Strong smells/odors bother you ___ Numbness/tingling
___ Dizziness/lightheadedness/vertigo ___ Increased sensitivity of Scalp Hair Ears
___ Eye tears ___ Runny or stuffy nose
___ Difficulty concentrating ___ Mood changes/irritability

Alleviating Factors: *During a headache, what makes you feel the most comfortable?*
___ Lying down/sleeping ___ Being in a dark room
___ Keeping physically active ___ Pacing back and forth
___ Massage ___ Tying something around your head
___ Cold pack on your head/neck ___ Hot pack on your head/neck

HEADACHE-RELATED DISABILITY

Effect of headaches on ability to function:

During milder headaches:
___ I am able to function normally
___ My ability to function is slightly decreased
___ My ability to function is severely decreased
___ I am totally bedridded

During Moderate or severe headaches:
___ I am able to function normally
___ My ability to function is slightly decreased
___ My ability to function is severely decreased
___ I am totally bedridded

Doctor visits for headache: How many times would you estimate that you have visited the following because of your headaches in the past year?
___ Family physician ____________
___ Walk-in clinic ____________
___ Emergency Department ____________

How many days of work or school have you missed in the past year because of headaches? ___________