Headache History (Confidential)

Name _____ Phone # _____ Date _____ Birth date _____

Western Diagnosis (if any) □ Sinus □ Migraine
□ Tension □ Cluster □ Other _____

Have you ever had a head injury or concussion □Y □N
Did symptoms start afterwards? □Y □N

CHECK ALL APPROPRIATE BOXES BELOW

CIRCLE: Better **OR** Worse **ONLY IF** it applies

Location of Pain

□ Top of head (vertex)
□ Temples
□ Both sides of head
□ One side only □ Right □ Left
□ Behind eyes
□ Forehead
□ Back of head (occiput)
□ Whole head
□ Sinuses
□ Changes from headache to headache
□ Radiates to _____
□ Time it comes on _____
□ Periodicity occurs every ____Day(s) ____ Wks ____Months _____ Year(s)
Other _____

Type of Pain check all that apply

□ Dull □ Sharp □ Bursting □ Stunning
□ Burning □ Feeling of heaviness
□ Throbbing □ Distending □ Wave like
□ Hangover □ Pressing □ Shooting
□ Pulling sensation □ Tearing
□ Stabbing (boring) □ Stitching
□ Sore Bruised □ Empty feeling
□ Band like where _____
□ Electric like
□ Stiffness (occiput, neck & shoulders)
□ Twitching muscles
□ Feels like _____
□ Other _____

Modalities

Daytime	better / worse
Evening or night	better / worse
Weekends	better / worse describe
Activity / Motion	better / worse _____
Rest	better / worse
Lying down	better / worse
Heat	better / worse
Cold	better / worse
Light	better / worse
Dark	better / worse
Sound	better / worse
Damp weather	better / worse
Anger	better / worse
Excitement	better / worse
After sex	better / worse
Hungry	better / worse
After eating/Drinking	better / worse _____
After sour foods	better / worse
Pre-menstruation	better / worse
During menstruation	better / worse
Post-menstruation	better / worse
Massage/pressure	better / worse
Jarring /sudden movement	better / worse
Dark room	better / worse
Bending Backwards	better / worse
Stooping	better / worse
Eye movement	better / worse
Thinking of it	better / worse
□ Reading □ Computer	better / worse
Comes and goes with sun/sunset	better / worse

Pain Intensity scale of 1-10 1 = mild 4-5 = painful still function 10 = worst pain I have ever had _____

Concomittants symptoms occur with headache check all that apply

Nausea □ before □ during □ after
Vomiting □ before □ during □ after
Diarrhea □ before □ during □ after
Coughing □ before □ during □ after
Drowsiness □ before □ during □ after
Mental confusion □ before □ during □ after
Vision disturbance describe _____
Must □ stand □ walk □ sit □ lie down □ before □ during □after explain _____
Other _____

Are you taking Hormones? For what condition? _____ Could there be a connection?

ADDITIONAL INFORMATION & COMMENTS

_____

Please print & fill out and bring with you to your appointment, thank-you.

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