HEADACHE HISTORY & PROFILE

NAME DATE OF BIRTH TODAY'S DATE

Where are your headaches located? On what part of the head do the headaches start?

__(R) Side __(L) Side __Either side __Both sides

__Back __On top __Temples __Behind / around eyes

__Forehead __Face __Neck __Other –

After the headache starts – Does it usually – Stay in one place ___ Move around ___ Please explain –

How would you describe the pain? - __Throbbing / pulsating __Pressing / squeezing __Stabbing __Sharp

__Dull / nagging __Other –

Describe the degree of pain (circle one #) – slight – 1 2 3 4 5 6 7 8 9 10 – worst imaginable

Do your headaches interfere or prevent normal activities – school, work, etc.? _ No _ Yes, If so how many days have been missed? ___

How long ago did the current headache 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 __worse __better __fluctuating __no change

Are any of the following symptoms associated with the headache? Please mark (B) before (√) during (A) after

__Spots before eyes – type –

__Blindness (R L)

__Blurring (R L)

__Double vision

__Can see only half of objects

__Eyelid droop (R L)

__Tearing (R L)

__Eye redness (R L)

__Eyes puffy (R L

__Light sensitivity

__Noise sensitivity

__Odors sensitivity

__Nose blocked / discharge (R L)

__Nausea __Vomiting

__Loss of appetite __Hunger

__Cramps __Diarrhea

Face – Scalp –

__Pale __Redness

__Sweating __Tender

__Puffy __Pain on chewing

__Decreased jaw opening

Neck -

__Stiff __Tender

__Difficulty concentrating

__Depression __Anxiety

__Fatigue __Irritability

Weakness (W) Numbness (N) Both (B)

__Face (R L) __Arms (R L)

__Arm & leg (R L)__Legs (R L)

__Difficulty talking (finding words)

__Difficulty understanding

__Numbness around lips

__Slurred speech

__Fainting (feel like or have fainted)

__Dizzy (lightheaded – unsteady – spinning)

Hands and / or feet –

__Cold __Pale

__Sweaty __Mottled

HEADACHE HISTORY & PROFILE (continued)

Indicate if any of the following factors have (√) brought on (trigger) or (x) worsen your headache –

__Head injury

__Sleep-too much-too little

__Emotional stress __during __after

__Depression – anxiety

__Physical activity

__Sitting up

__Bending over

__Straining – coughing

__Missed meal

__Change in weather

__Seasons –

_Allergies __MSG

__Processed meats

__Chocolate __Citrus Fruits

__Cheeses

__Caffeine

__Other foods

__Mediations

__Menstrual periods

__Other ____________

Do any blood relatives have severe headaches? _ No _ Yes Who & Diagnosis -

Which of the following makes the headache better? __Rest __Activity __Darkness __Quiet __Compresses __Tylenol / Motrin

__sleep _Scalp or temple pressure __Other______________________________________

Have you been sad or worried about anything?

Previous professional treatment of headache? _ No _ Yes – Who & When –

Previous x-ray or other investigations of headache? _ No _ Yes – Describe –

Previous medications for headache? _ No _ Yes Name – dosage

Other current medications? Please list – include over the counter drugs

DRUG ALLERGIES

ADDITIONAL NOTES