

HEADACHE INTAKE ASSESSMENT FORM

NAME: _____

AGE: _____ SEX: M F MARITAL STATUS: _____

NAME OF SPOUSE: _____

NAME(S) AND AGE(S) OF CHILDREN: _____

EDUCATION: _____

OCCUPATION: _____ SPOUSE'S OCCUPATION: _____

DOES ANYONE IN YOUR FAMILY HAVE HEADACHES, OR HAVE THEY HAD MODERATE-TO-SEVERE HEADACHES IN THE PAST? _____

HOW OFTEN DO YOU HAVE A MODERATE-TO-SEVERE HEADACHE? _____

HOW LONG DO THE SEVERE HEADACHES LAST? ___ Hours ___ One Day ___ Two Days
___ Three to Several Days

ON A SCALE OF ONE TO TEN, TEN BEING THE WORST, HOW SEVERE ARE THE HEADACHES?

1	2	3	4	5	6	7	8	9	10
Mild			Moderate				Severe		

HOW OLD WERE YOU WHEN YOU STARTED HAVING HEADACHES? _____

DO YOU HAVE SOME TYPE OF HEADACHE EVERY DAY? _____

HOW MUCH DO THESE DAILY HEADACHES BOTHER YOU? ___ Mildly ___ Moderately ___ Severely

WHERE DOES THE PAIN HURT ON THE DAILY HEADACHES? _____

WHERE DOES THE PAIN HURT ON THE SEVERE HEADACHES? _____

WHAT KIND OF PAIN IS IT? ___ Sharp ___ Pounding ___ Aching ___ Other: _____

DOES YOUR EYE TEAR ON THE SIDE OF THE HEADACHE? _____

ARE THE HEADACHES MUCH WORSE IN THE LAST FEW MONTHS? _____

ARE THE HEADACHES MUCH WORSE IN THE LAST YEAR? _____

DO YOU FREQUENTLY HAVE NAUSEA WITH THESE HEADACHES? ___ DOES IT BOTHER YOU? ___

DO YOU HAVE ANY VISUAL PROBLEMS, SUCH AS FLASHING LIGHTS OR SPRINKLES OF LIGHT, OR LOSE YOUR VISION TO ONE SIDE WITH A HEADACHE? _____

(FOR WOMEN ONLY)

ARE THE HEADACHES MUCH WORSE BEFORE OR DURING THE MENSTRUAL PERIOD? _____

ARE YOU ON ANY BIRTH CONTROL PILL OR HORMONE? _____

DOES STRESS PLAY A ROLE IN THE HEADACHES? _____

CIRCLE THE FOLLOWING IF THESE PLAY A ROLE IN YOUR HEADACHES OR IN PRODUCING AN OCCASIONAL HEADACHE:

- | | |
|---------------------------|--------------------|
| Stress | Exercise |
| Weather Changes | Missing a Meal |
| Foods | Cigarette Odor |
| Bright Sunlight | Perfume Odors |
| After Stress is Over | Different Seasons: |
| Undersleeping | Summer |
| Oversleeping | Fall |
| Hormonal Changes, such as | Winter |
| menstrual cycle | Spring |
| Exertion | |
| Sexual Activity | |

DO YOU HAVE VERY COLD FEET AND HANDS IN THE WINTER? _____

HAVE YOU HAD A CAT SCAN FOR THE HEADACHES? _____ IF SO, WHEN? _____

HAVE YOU HAD AN MRI FOR THE HEADACHES? _____ IF SO, WHEN? _____

HAVE YOU HAD BLOOD TESTS IN THE PAST YEAR? _____ WERE THEY NORMAL? _____

HAVE YOU HAD ANY BIOFEEDBACK OR RELAXATION TRAINING FOR HEADACHES? _____
IF SO, HAS IT HELPED? _____

WHICH DOCTORS/HEADACHE DOCTORS HAVE YOU SEEN FOR HEADACHES, IF ANY? _____

WHAT MEDICATIONS HAVE YOU TAKEN FOR HEADACHES?	DID IT HELP?

DO YOU SMOKE CIGARETTES? _____

DO YOU DRINK ALCOHOL? ___ Rarely ___ Occasionally ___ Very Frequently

HAVE YOU HAD ANY TYPE OF PROBLEM WITH ADDICTIVE DRUGS IN THE PAST? _____

DO YOU TEND TO BE ANXIOUS OR NERVOUS? _____ Is the anxiety ___ mild, ___ moderate,
or ___ severe?

DO YOU HAVE TROUBLE ___ SLEEPING, ___ GOING TO SLEEP, OR ___ STAYING ASLEEP?

DO YOU TEND TO BE DEPRESSED VERY OFTEN? _____

HAVE YOU BEEN DEPRESSED LATELY? _____

OTHER PAST MEDICAL HISTORY:

OPERATIONS? _____

ULCERS OR STOMACH PROBLEMS? _____

SIDE EFFECTS OR ALLERGIES TO ANY MEDICATIONS? _____

ASTHMA? _____

ANY OTHER MEDICAL PROBLEMS? _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? _____
