CONSULT: HEADACHE

What brought you to our clinic: ________________________________________________________________

HEADACHE HISTORY

Age of onset ______________ When did headaches become a problem? __________________________________

Was there a trigger for your current headache problem?

☐ Specific Stress
☐ Injury
☐ Motor vehicle accident
☐ Illness
☐ Menarche or pregnancy or birth control pills or hormone replacement
☐ Other (please specify) ___________________________________________________________

HEADACHE CHARACTERISTICS (circle all that apply)

How often do you have headaches? ______________________ Are they increasing in frequency YES NO

Onset of headaches: Gradual Suddenly Varies

Duration of Headaches: Minutes Hours Days

Do your headaches prevent you from doing: Activities School Work Household chores?

Location of headaches: Left side Right side Both/other

Pain Type: Pressure Stabbing Throbbing Tight band

What brings on your headaches or triggers your headaches? (circle all that apply)

Food Hunger Fatigue Stress Menstruation

Coughing Odors Too Much Caffeine Alcohol Wine

Too Little Sleep Sexual Activity Bright Lights/Sun After Stress (first day of vacation, weekend, etc)

Prolonged Computer Work Weather Changes Loud Sounds

Pre-headache symptoms: (circle all that apply)

Mood changes Personality changes Change in appetite Food cravings

Neck pain Fatigue None other __________________________

Aura Symptoms: (circle all that apply)

Bright lights/flashes of lights/multi-colored lights Zigzag lines Paralysis Numbness/tingling

Dizziness/vertigo Partial loss of vision/blurry vision/blindness Upset stomach/nausea none

Symptoms during headaches:

Nausea/upset stomach Vomiting Bright lights/sun bothers you Numbness or tingling

Eye tears Odors bother you Difficulty concentrating Nose symptoms

Loud sounds bother you Dizziness/lightheadedness/vertigo Increased sensitivity of scalp/hair/ears

Mood changes Irritability
Alleviating factors:
- Lying down/sleeping
- Being in dark room
- Keeping physically active
- Pacing back-and-forth
- Massage
- Cold pack
- Hot pack

HEADACHE-RELATED DISABILITY:

How many days of work or school have you missed in past year because of headache? ____________________________

Number of doctors visits for headache in past year?
- Primary Care Provider ________
- Emergency department ________
- Walk-in Clinics ________

What is your ability to function during headaches?
- Normal
- Slightly decreased
- Severely decreased
- Totally bedridden

HEADACHE-RELATED INVESTIGATIONS (CIRCLE ALL THAT APPLY)

Previous testing:
- CT scans
- MRI
- EEG
- Sinus X-ray
- Neck X-ray
- Other

Previous consultations:
- Neurologist
- Pain Clinic
- ENT Specialist
- Eye Doctor
- Dentist
- Internal Medicine
- Psychiatrist
- Therapist
- Allergy Specialist

HEADACHE SPECIFIC TREATMENTS

Multi-disciplinary health care and headache purchases:
- Chiropractor
- Psychologist
- Nutritionist
- Acupuncturist
- Naturopath/homeopath/herbalist
- Physiotherapist
- Massage Therapist
- Aromatherapy
- Hot packs
- Cold packs
- Eye masks
- Self-help books
- Mouth guard
- Herbs-supplements
- Other ____________________________

Current headache medications (please list with doses, prescription and over the counter AND as needed medications):
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Previous headache medications that you are no longer taking (prescription and over the counter):
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

How long does it take to become pain-free after taking medication?
- < 1 hour
- 1-2 hours
- >2 hours
- I never become pain-free after medication

Has your pain or its treatment disrupted your relationship with family or friends? YES NO
If yes, describe ____________________________

What other medical conditions do you have (circle all that apply)?
- High Blood pressure
- Heart Disease
- Diabetes
- Blood disorder
- Lung disorder
- Kidney disorder
- Liver disorder
- Anxiety
- Depression
- Other ____________________________

What surgeries have you had?
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
FAMILY HISTORY:
Any other family members with headaches or similar health conditions? Who/what?

SOCIAL HISTORY:
Marital Status:
- Married
- Single
- Separated
- Divorced
- Widowed

Do you have children? YES NO
Do you drive? YES NO

Work status:
- Working
- Not working
- Retired
- Disabled
- Veteran
- Homemaker
- Student

Occupation

Do you drink caffeinated beverages? YES NO

How many per day? ____________________________

Alcohol use:
- Never
- Rare
- Frequent
- Occasionally
- Alcohol dependant
- Recovered alcoholic

Drinks per week ____________________________

Tobacco use:
- Cigarettes ____________________________ per day
- Cigars ____________________________ per day
- Smokeless tobacco ______________________ per day

I quit smoking on (date): _______________________

2101 W. Arlington Blvd.
Suite 100
Greenville MRI
2090-A W. Arlington Blvd.
#9 & #10 Doctors Park

(252)752-5000