AULTMAN
Center for Pain Management

HEACHACHE ASSESSMENT

To complete questionnaire - please check the box or fill in the blanks with the best answer.

Patient History

Name: Date:

Birth date: Age: ◯ male ◯ female

Referring physician: Primary physician:

Reason for visit:

Past treatment: ☐ headache clinic ☐ pain management center ☐ none

Location of clinic or center:

Past testing: ☐ MRI ☐ MRA ☐ CT scan ☐ EEG ☐ Sleep study ☐ Lab tests

Where were these completed?

PLEASE BRING ALL REPORTS OF TREATMENT OR TESTING WITH YOU TO THE FIRST VISIT.

Headache History

Do you have more than one headache type: ☐ Yes ☐ No

If yes, briefly describe the different headaches here:

First headache type:

Second headache type:

Are you ever HEADACHE FREE? ◯ Yes ◯ No When?

Onset of first headache: started years ago I was_____years old

Precipitating event (what provoked your **first** headache?)

☐ none known ☐ menarche (first period) ☐ injury:

☐ pregnancy ☐ other:

Current pattern: ☐ sudden ☐ rapid ☐ gradual ☐ varies

Time of day: ☐ morning ☐ afternoon ☐ evening ☐ night ☐ awaken from sleep ☐ varies

Frequency (number of attacks): *Fill in the number*

_____per day _____per week _____per month _____per year

☐ continuous ☐ lifetime attacks

Are they increasing in frequency? ◯ Yes ◯ No

Duration (how long do they last?) *Fill in the number*

with medication _____minutes _____hours _____days

without medication _____minutes _____hours _____days

How often do they recur within 24 hours: *with* medication *without* medication

Provoking factors (things that bring on a headache)

Food/beverage: ☐ fasting ☐ chocolate ☐ caffeine ☐ nitrates
☐ MSG ☐ alcoholic beverages -what ones in particular?
☐ other:

Physical exertion: ☐ coughing ☐ talking ☐ chewing ☐ exercise
☐ sexual intercourse

Hormonal: Menses: ☐ before ☐ during ☐ after
☐ pregnancy ☐ menopause

Stress: ☐ work ☐ home ☐ family ☐ spouse
☐ other:

Environmental: ☐ allergies ☐ weather changes ☐ altitude ☐ sunlight
☐ other:

Sleep: ◯ lack of sleep ◯ too much sleep ◯ change in wake/sleep

How many hours of sleep do you average? ◯ 1-3 ◯ 3-5 ◯ 5-7 ◯ 7-8 ◯ 8-10

Other triggers: _____

What makes your headache worse? _____

How do your headaches affect your ability to function? Write in the number of days missed.

work productivity _____ days/month missed

school _____ days/month missed

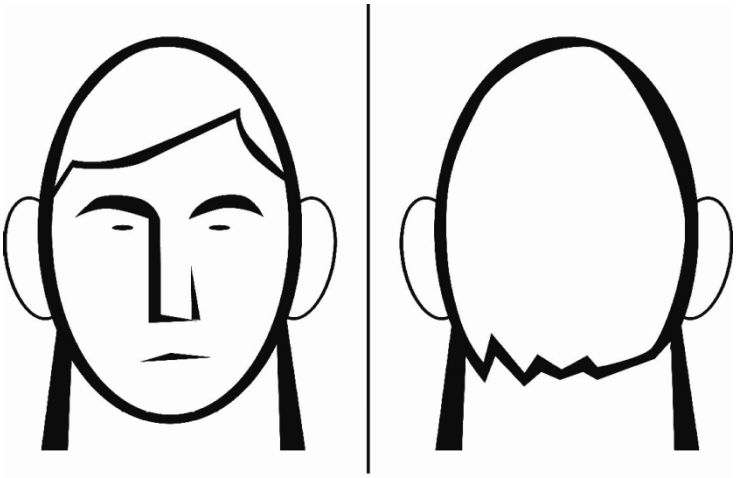
social/family activities _____ days/month missed

Severity: how bad is the pain on a scale of 0-10, where 0 is no pain and 10 is the most unbearable.

today 0-----1-----2-----3-----4-----5-----6-----7----8------9-----10 (Circle the number)

best day 0----1----2-----3----4-----5-----6-----7----8-----9----10

worst day 0----1----2-----3----4-----5-----6-----7----8-----9----10



Right **Left** **Left** **Right**

Please place an X on the drawing to show the location(s) of your pain.

What symptoms do you experience with your headache?

- ☐ nausea
- ☐ diarrhea
- ☐ vomiting
- ☐ sensitivity to sound
- ☐ dizziness
- ☐ stuffy/runny nose
- ☐ red/teary eyes
- ☐ sensitivity to light
- ☐ vision change
- ☐ numbness/tingling
- ☐ ringing in the ears
- ☐ sensitivity to smell
- ☐ anorexia (loss of appetite)

Check any of the following that you have used to reduce the frequency of and duration of your headache:

- ☐ biofeedback
- ☐ exercise
- ☐ stress management
- ☐ chiropractic treatments
- ☐ cervical epidural injections
- ☐ ice
- ☐ occipital blocks
- ☐ heat
- ☐ relaxation techniques
- ☐ pain management center
- ☐ alternative medicine clinic
- ☐ herbal remedies
- ☐ massage therapy
- ☐ acupuncture
- ☐ counseling
- ☐ TENS

Do you have allergies to: ☐ dyes ☐ iodine ☐ tyramine ☐ latex

Do you experience fatigue or a drained feeling following the resolution of your headache? ◯ Yes ◯ No

Social History

◯ single ◯ married ◯ widowed ◯ divorced ◯ separated

If married, fill in your spouse's age:_____ occupation:_____

Spouse's general health status:

Who resides in your home? ☐ live alone ☐ children at home

live with:

Do you smoke? ◯ Yes ◯ No ☐ Never smoked ☐ Second hand smoke

Do you consume alcohol? ◯ Yes ◯ No

If yes, what type and how often?

Do you use illicit or recreational drugs? ◯ Yes ◯ No

If yes, what kind how often?

Have you ever had a problem with drug or alcohol abuse? ◯ Yes ◯ No

What is your level of education?

◯ less than high school ◯ highest grade level completed:_____

◯ high school ◯ some college

◯ bachelor's degree ◯ associate/technical degree

List your hobbies: _____

What is your occupation? _____

Current employer:

Previous employer:

Are you working now? ◯ yes ◯ no If no, last date worked: disabled ☐

Describe your work: _____

How many hours per day do you spend:

_____sitting _____walking _____standing

_____driving _____ lifting _____how many pounds?

Please rate how well you like your job (circle): don't like-----1-----2-----3-----4-----5----love

Rate your level of anger (circle): low-----1-----2-----3-----4-----5-----high

Medical History

General health: ◯ excellent ◯ good ◯ fair ◯ poor

Have you had any of the following medical problems?

☐ diabetes	☐ arthritis	☐ asthma
☐ hypertension	☐ neck/spine	☐ ulcers/stomach problems
☐ heart disease	☐ problems	☐ kidney/renal disease
☐ stroke/TIA	☐ skin problems	☐ infectious disease
☐ seizure/epilepsy	☐ cancer	☐ gynecologic problems
☐ head injury	☐ hepatitis/liver	☐ psychiatric problems
☐ lung disease	☐ disease	☐ hospitalizations
☐ dental problems	☐ phlebitis	☐ ear, nose, throat problems
☐ thyroid disease	☐ other	

If you have been hospitalized or had surgery, please list the date, reason, and hospital: _____

Current Medications (including herbals, vitamins, over the counter, and prescription): _____

Past Medications taken for headaches: _____

Vital Signs (for medical staff use only)

Pulse:	Blood Pressure:	Respirations:
Height:	Weight:	

Comments: _____

Medication Questionnaire

Please mark any of the following medications that you have taken in the past:

MEDICATIONS	YES	NO	MEDICATIONS	YES	NO	MEDICATIONS	YES	NO
NSAIDS			**Analgesics**			**Antidepressants**		
Motrin			Acetaminophen			Zoloft		
Advil			Tylenol			Paxil		
Ibuprofen			Midrin			Pamelor		
Toradol			Fiorcet			Nardil		
Naproxen Sodium			Tylenol #3			Phenelzine		
Excedrin Migraine			Vicodin			Elavil		
Indocin			Demerol			Trazodone		
Diclofenac			Darvocet			**Beta Blockers**		
Antiemetics			Darvon			Inderal		
Compazine			Percocet			Nadolol		
Phenergan			Talwin			Atenolol		
Zofran			Oxycodone			Metroprolol		
Tigan			Fiorinal			Blocardren		
Calcium Channel Blockers			**Triptans**			Topol XL		
Verapamil			Immitrex			Inderal LA		
Diltiazem			Zomig			**Other**		
Nimodipine			Axert			Cyroheptadine		
Anticonvulsants			Maxalt			Sansert		
Depakote			Amerge			Estradiol		
Depakote ER						Feverfew		
Neurontin						Vitamin B12		
Gabitril						D.H.E.A.		
Topamax						Propofol		

Please list any medications you take that are not listed above:

Thank you for providing this very important information.

PLEASE READ THE FOLLOWING:

This questionnaire will become part of your Medical Record. Any false information or omissions may lead to termination of treatment from Pain Management Center. Complications and side effects due to falsifications or omissions are the responsibility of the patient.

I verify that the above information is accurate and complete.

_____ _____

Signature Date