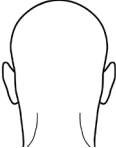



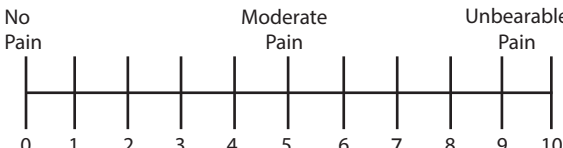


## PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

Please review and answer all parts of each question with our staff. Provide specific details/notes in the right hand column.

#	QUESTIONS																																													
1	<p>How often do you get severe headaches/migraines that make it difficult to function without treatment or medication?</p> <p>» <input type="checkbox"/> Occasionally    » <input type="checkbox"/> More than twice a year    » <input type="checkbox"/> More than once a month    » <input type="checkbox"/> More than once a week</p>																																													
2	<p>How often do you get other milder headaches?</p> <p>» <input type="checkbox"/> Daily    » <input type="checkbox"/> More than 3 per week    » <input type="checkbox"/> More than 2 per month    » <input type="checkbox"/> Other Please specify: _____</p>																																													
3	<p>Have your headaches changed in the last six months?</p> <p>» <input type="checkbox"/> About the same    » <input type="checkbox"/> Slight worsening    » <input type="checkbox"/> Same but more frequent    » <input type="checkbox"/> A lot worse    » <input type="checkbox"/> New type of headache</p> <p>» <input type="checkbox"/> Got worse when _____</p>																																													
4	<p>Where are your headaches located? (Mark Locations) <span style="float: right;">On a scale of 1-10, how painful are your headaches/migraines?</span></p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">  Back         </div> <div style="text-align: center;">  Front         </div> <div style="text-align: center;">  Right Side         </div> <div style="text-align: center;">  Left Side         </div> </div> <div style="text-align: center; margin-top: 10px;">  </div>																																													
5	<p>Describe the type of headache pain you feel most often:</p> <p>» <input type="checkbox"/> Achy    » <input type="checkbox"/> Throbbing    » <input type="checkbox"/> Stabbing    » <input type="checkbox"/> Other _____</p>																																													
6	<p>What other doctors have you seen or tests have you had for your pain headaches, and/or migraines</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> <input type="checkbox"/> GP / FAMILY DOCTOR _____  <input type="checkbox"/> DENTIST (IF OTHER) _____  <input type="checkbox"/> ORAL/MAXILLOFACIAL SPECIALIST _____  <input type="checkbox"/> PSYCHIATRIST/PSYCHOLOGIST _____         </td> <td style="width: 50%; padding: 5px;"> <input type="checkbox"/> PHYSICAL THERAPIST _____  <input type="checkbox"/> CHIROPRACTOR _____  <input type="checkbox"/> MRI/CT SCAN/BLOOD WORK _____  <input type="checkbox"/> OTHER _____         </td> </tr> </table>	<input type="checkbox"/> GP / FAMILY DOCTOR _____ <input type="checkbox"/> DENTIST (IF OTHER) _____ <input type="checkbox"/> ORAL/MAXILLOFACIAL SPECIALIST _____ <input type="checkbox"/> PSYCHIATRIST/PSYCHOLOGIST _____	<input type="checkbox"/> PHYSICAL THERAPIST _____ <input type="checkbox"/> CHIROPRACTOR _____ <input type="checkbox"/> MRI/CT SCAN/BLOOD WORK _____ <input type="checkbox"/> OTHER _____																																											
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7	<p>What medications do you use for headache, migraine, or pain relief?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">MEDICATION (NAME OF MEDICATION OR SUBSTANCE)</th> <th style="width: 30%;">WHAT DOSE?</th> <th style="width: 30%;">HOW OFTEN?</th> </tr> </thead> <tbody> <tr><td>Acetaminophen, Tylenol</td><td></td><td></td></tr> <tr><td>Ibuprofen, Advil, Motrin, Nuprin, etc..</td><td></td><td></td></tr> <tr><td>Naproxin, Aleve</td><td></td><td></td></tr> <tr><td>Rx pain medication ( )</td><td></td><td></td></tr> <tr><td>Rx pain medication ( )</td><td></td><td></td></tr> <tr><td>Rx muscle relaxant ( )</td><td></td><td></td></tr> <tr><td>Rx anxiety medication ( )</td><td></td><td></td></tr> <tr><td>Rx depression medication ( )</td><td></td><td></td></tr> <tr><td>Rx migraine medication ( )</td><td></td><td></td></tr> <tr><td>Medication for sleeping ( )</td><td></td><td></td></tr> <tr><td>Caffeine intake ( )</td><td></td><td></td></tr> <tr><td>Alcohol intake ( )</td><td></td><td></td></tr> <tr><td>THC, Medical Marijuana ( )</td><td></td><td></td></tr> <tr><td>Other: ( )</td><td></td><td></td></tr> </tbody> </table>	MEDICATION (NAME OF MEDICATION OR SUBSTANCE)	WHAT DOSE?	HOW OFTEN?	Acetaminophen, Tylenol			Ibuprofen, Advil, Motrin, Nuprin, etc..			Naproxin, Aleve			Rx pain medication ( )			Rx pain medication ( )			Rx muscle relaxant ( )			Rx anxiety medication ( )			Rx depression medication ( )			Rx migraine medication ( )			Medication for sleeping ( )			Caffeine intake ( )			Alcohol intake ( )			THC, Medical Marijuana ( )			Other: ( )		
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8	<p>Do you try non-medicating techniques for managing your headaches?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>» <input type="checkbox"/> Yoga    » <input type="checkbox"/> Breathing Exercises    » <input type="checkbox"/> Cold Packs    » <input type="checkbox"/> Massage    » <input type="checkbox"/> Meditation    » <input type="checkbox"/> Physical Therapy</p> <p>» <input type="checkbox"/> Other (please describe) _____</p>																																													