HEADACHE HISTORY

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PATIENT INFORMATION

NAME	DATE TODAY / /	AGE	SEX	TELEPHONE

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

 # QUESTIONS

1 How often do you get severe headaches/migraines that make it difficult to function without treatment or medication?

» ☐ Occasionally » ☐ More than twice a year » ☐ More than once a month » ☐ More than once a week

2 How often do you get other milder headaches?

» ☐ Daily » ☐ More than 3 per week » ☐ More than 2 per month » ☐ Other Please specify: ____

3 Have your headaches changed in the last six months?

» ☐ About the same » ☐ Slight worsening » ☐ Same but more frequent » ☐ A lot worse » ☐ New type of headache

» ☐ Got worse when ____

4 Where are your headaches located? (Mark Locations)

Back Front Right Side Left Side

On a scale of 1-10, how painful are your headaches/migraines?

No Pain — Moderate Pain — Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

5 Describe the type of headache pain you feel most often:

» ☐ Achy » ☐ Throbbing » ☐ Stabbing » ☐ Other ____

6 What other doctors have you seen or tests have you had for your pain headaches, and/or migraines

☐ GP / FAMILY DOCTOR	____	☐ PHYSICAL THERAPIST	____
☐ DENTIST (IF OTHER)	____	☐ CHIROPRACTOR	____
☐ ORAL/MAXILLOFACIAL SPECIALIST	____	☐ MRI/CT SCAN/BLOOD WORK	____
☐ PSYCHIATRIST/PSYCHOLOGIST	____	☐ OTHER	____

7 What medications do you use for headache, migraine, or pain relief?

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: ( )		

8 Do you try non-medicating techniques for managing your headaches? ☐ Yes ☐ No

» ☐ Yoga » ☐ Breathing Exercises » ☐ Cold Packs » ☐ Massage » ☐ Meditation » ☐ Physical Therapy

» ☐ Other (please describe) ____

I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION BEST DESCRIBES THE TREATMENTS AND MEDICATIONS I HAVE USED TO HELP ALLEVIATE MY HEADACHES/MIGRAINES/PAIN.

PATIENT SIGNATURE: ____