Headache Intake Assessment Form

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Name: _____Date:_____

Age: _____ Sex: M F Marital Status _____

Name of Spouse: _____

Name(s) and Age(s) of children:_____

_____

Names & Types of Pets: _____

Education: _____

Occupation: _____ Spouse's occupation:_____

Does anyone in your family have headaches, or have they had moderate-to-severe headaches in the past? _____

How old were you when you started having headaches? _____

How often do you have a mild -moderate headache? _____

How often do you have a severe headache/ migraine? _____

How long do the severe headaches last? __hours __one day __ two days __three or more 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

Do you have some type of headache every day? _____

How much do these daily headaches bother you? Mildly _____ Moderately _____ Severely ____

Where does the pain occur for your daily headaches? _____

Where does the pain occur for your severe headaches/migraines?_____

What does your headache typically feel like? (please circle one)

Throbbing/pulsing *Pressing/squeezing* *sharp/stabbing* *dull/achy*

Does your eye tear on the side of the headache? Yes No

Are the headaches much worse in the last few months? Yes No

Are the headaches much worse in the last year? Yes No

Do you frequently have nausea with your headaches? Yes No

Do you typically have visual problems with your headaches; such as flashing lights, sprinkles of light, or vision loss on one side? Yes No

Do you typically experience sensitivity to light? Yes No

Do you typically experience sensitivity to sound? Yes No

Are your headaches worse before or during your menstrual cycle? Yes No

Do you take any birth control pill or hormone? _____

Circle the following if these play a role in your headaches or in producing an occasional headache:

stress
after stress is over
weather changes
foods
bright sunlight
sexual activity
under sleeping
oversleeping
hormonal changes
menstrual cycle

exercise
exertion
missing a meal
cigarette odor
perfume odors
different seasons:
summer
fall
winter
spring

Do you have very cold feet and hands in the winter? _____

Have you had any of the following tests?

CT scan for your headaches? Y or N If so, when? _____Results _____

MRI for the headaches? Y or N If so, when? _____ Results_____

Blood tests in the past year? _____ Were they normal?_____

Have you tried Biofeedback or relaxation training for headaches? Yes No

If yes, has it helped? _____

_____

How much do you exercise, and what do you do? _____

_____

Which doctors have you seen for headaches, if any? _____

_____

_____

_____

Which family doctors or other doctors do you see? _____

_____

_____

_____

Do you smoke cigarettes? Yes No *If yes*, how many_____

Do you drink alcohol? Never Occasionally Daily

Do you drink water? Yes No *If yes,* how much per day? 20oz 16oz 32oz more

Have you had any type of problem with addictive drugs in the past? _____

Do you tend to be anxious or nervous? Yes No

If yes, is your anxiety mild, moderate, or Severe? _____

Do you have trouble Sleeping? Y N If yes, do you have trouble going to sleep? Or staying asleep? _____

Do you have a history of depression? Y or N If yes, when was your last episode? _____

Is/was it: Mild Moderate or Severe

Do you eat breakfast? Yes No Please describe: _____

...Lunch? Yes No Please describe:_____

...Dinner? Yes No Please describe:_____

...Snacks? Yes No Please describe:_____

Other past medical history:

Operations? _____

_____

Ulcers or stomach problems? _____

_____

Asthma? _____

_____

Any other medical problems? _____

_____

_____

_____

Side effects or allergies to any medications? _____

_____

_____

What medications are you **currently** taking? _____

_____

_____

_____

_____

_____

_____

_____

STRESS FORM

Name: _____**Date:**_____

Do you have any siblings? Names and ages (if applicable)

_____

_____

Describe briefly (personality traits, medical problems, etc.):

Father: _____

Mother: _____

List several traits which best describe your personality: _____

_____

_____

_____

History of clinical/counseling intervention: Yes No

If yes, was it *Inpatient* or *Outpatient* *(circle one)* **Dates:** _____ **Currently ongoing**: Yes No

Primary Therapist was/is: *(circle one)* Psychiatrist Marriage Counselor Psychologist Social Worker

Other (*Please describe*) _____

Primary reason for seeing the above: _____

_____

_____

_____

Current areas in which I am under stress include the following: (circle all that apply)

Work	Marriage	Relationship/Interactions w/ parents
School	Financial Pressure	Relationship/ Interactions w/ children
Time Management	other (please list below)	none of the above

Please elaborate briefly on any items checked above: _____

_____

_____

_____

Please note if any of the following apply to you: you may elaborate briefly on any that apply

History of alcoholism in family _____

_____

Emotional abuse as a child _____

_____

Physical abuse as a child _____

_____

Early or recent head injury _____

_____

Suicidal thoughts (past or present) _____

_____

Friends and family members do not understand or appreciate the nature of your headaches:

_____

_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

MEDICATION HISTORY FORM

Please highlight or circle medications you have tried, and if they worked or any side effects.

Over the Counter

Aspirin | Aleve | Excedrin Migraine | Anacin
Acetaminophen (Tylenol) | Aspirin Free Excedrin | Ibuprofen (Motrin, Advil, etc.)

Herbal

Feverfew | Vitamin B2 (riboflavin) | Petadolex (butterbur) | Magnesium Oxide

Prescription Pain Medications

Naproxen Sodium (Anaprox, Naprelan, Naprosyn)
Fioricet (Butalbital, Acetaminophen, Caffeine)
Fiorinal (Aspirin/Butalbital/Caffeine)
Fiorinal/Fioricet with Codeine/Fiorinal #3
Esgic Plus (Acetaminophen/Butalbital/Caffeine)
Esgic (Acetaminophen/Butalbital/Caffeine)
Phrenilin (Butalbital/Acetaminophen)
Percocet, Percodan, Tylox (Oxycodone)
Vicodin, Vicoprofen, Lorcet (Hydrocodone)
Morphine IV/IM MS Contin, Kadian, Avinza
Panlor Acetaminophen/Caffeine/Dihydrocodeine)
Ultram (Tramadol) Ultracet
Lidoderm Patch
Butrans
Methadone (Dolophine)
Norgesic, Norgesic Forte, Norflex
Tylenol #3 or #4
Fentora
Oxycontin
Toradol (Ketorolac) Tabs,injections
Sprix Nasal Spray
Stadol Nasal Spray
Demerol (Meperidine)

Headache Medications

Treximet
Imitrex (Sumatriptan) tablets, Nasal Spray & Injections
Maxalt (Rizatriptan) tablet or MLT (dissolves)
Axert (Almotriptan)
Amerge (Naratriptan)
Zomig (Zolmitriptan) or ZMT (dissolves), Nasal Spray
Relpax
Frova
Sumavel Dose Pro
Ergomar SL
Cafergot Tab, supp., Cafergot PB supp.
Midrin (isomethep/dichloralphen/acet.)
Prodrin
DHE IV, IM
Cambia
Migranal Nasal Spray
Alsuma

Anti Inflammatory

Voltaren (Diclofenac sodium)
Arthrotec
Any other anti inflammatories
Celebrex (Celecoxib)
Mobic (Meloxicam)
Indocin (Indomethacin)

Blood Pressure

Inderal (Propranolol)
Metoprolol (Lopressor, Toprol XL)
Nadolol (Corgard)
Atenolol (Tenormin)
Bystolic
Verapamil (Calan, Covera HS)
Cozaar , Hyzaar
Benicar
Losartan

Anti-Depressant Medications

Vivactil (Protriptyline)
Elavil (Amitriptyline)
Pamelor (Nortriptyline, Aventyl)
Doxepin (Sinequan)
Desipramine (Norpramin)
Lexapro (Escitalopran)
Prozac (Fluoxetine)
Wellbutrin (Buproprion)
Viibryd
Zoloft (Sertaline)
Cymbalta
Pristiq
Paxil (Paroxetine)
Remeron (Mirtazapine)
Trazodone (Desyrel)
Effexor (Veniafaxine)

Anti-Seizure Medications

Topamax (Topiramate)
Zonegran
Trileptal (Oxcarbamezaapine)
Depakote
Gabitril
Neurontin (Gabapentin), Gralise
Keppra

Mood Stabilizer

Lithium (Eskalith, Lithobid)
Saphris
Lamictal (Lamotrigine)
Abilify
Seroquel (Quetiapine), XR
Zyprexa

Muscle Relaxers Medications

Skelaxin (Metaxalone)
Zanaflex (Tizanidine)
Flexeril (Cyclobenzaprine)
Parafon Forte (Chlorzoxazone)
Soma (Carisoprodol)

Anti Nausea Medications

Compazine (Prochloperazine)
Reglan (Metoclopramide
Phenergan (Promethazide)
Tigan (Trimethobenzamide)
Zofran (Ondansetron)

Anxiety

Xanax (Alprazolam)
Diazepam (Valium)
Ativan (Lorazepam)
Klonopin (Clonazepam)
Buspar (Buspirone)

Corticosteroids

Medrol Prednisone Decadron Solumedrol PO, IV

Other Medications of Treatment:

Botulinum Toxin (Botox) Trigger Point Shot

ADD / ADHD

Dexedrine Intuniv Adderall Adderall XR Concerta
Vyvanse Ritalin Focalin Focalin XR

Fibromyaligia

Lyrica Savella

Sleep Medications

Ambien Rozerem Lunesta

Emergency Room

What medications worked in the emergency room?

What medications didn't work in the emergency room?