# NeuroCare Center Pain Management
# Headache 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

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:

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What makes your headache worse? ____________________

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

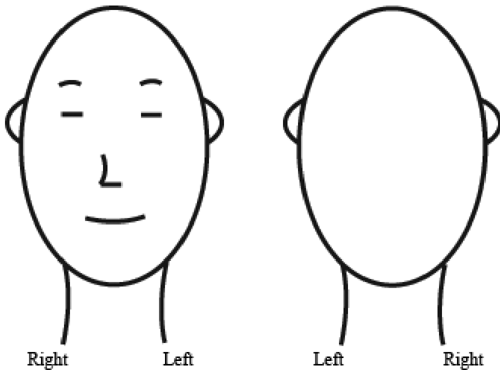
work productivity __________ days/month missed

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 (circle the number)

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




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

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: ________________________
S
pouse'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 and how often?

Have you ever had a problem with drug or alcohol abuse?

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What is your level of education?
☐ less than high school - highest grade level completed: ___________
☐ high school ☐ some college
☐ bachelor's degree ☐ associate/technical degree
☐ advanced 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 problems | ☐ ulcers/stomach problems |
| ☐ heart disease | ☐ skin problems | ☐ kidney/renal disease |
| ☐ stroke/TIA | ☐ cancer | ☐ infectious disease |
| ☐ seizure/epilepsy | ☐ hepatitis/liver disease | ☐ gynecologic problems |
| ☐ head injury | ☐ phlebitis | ☐ psychiatric problems |
| ☐ ear, nose, throat problems | ☐ thyroid disease | ☐ hospitalizations |
| ☐ dental problems | ☐ lung disease | ☐ other: |

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

Current medications:

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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:**

NSAIDS:
☐ Motrin
☐ Advil
☐ Ibuprofen
☐ Toradol
☐ Naproxen Sodium
☐ Excedrin Migraine
☐ Indocin
☐ Diclofenac

Analgesics:
☐ Acetominophen
☐ Tylenol
☐ Midrin
☐ Florcet
☐ Tylenol #3
☐ Vicodin
☐ Demerol
☐ Darvocet
☐ Darvon
☐ Percocet
☐ Talwin
☐ Oxycodone
☐ Fiorinal

Antidepressants::
☐ Zoloft
☐ Paxil
☐ Pamelor
☐ Nardil
☐ Phenelzine
☐ Elavil
☐ Trazodone

Antiemetics:
☐ Compazine
☐ Phenergan
☐ Zofran
☐ Tigan

Triptans:
☐ Imitrex
☐ Zomig
☐ Acert
☐ Maxalt
☐ Amerge

Beta Blockers:
☐ Inderal
☐ Nadolol
☐ Atenolol
☐ Metroprolol
☐ Biocardren
☐ Topol XL
☐ Inderal LA

Calcium Channel Blockers:
☐ Verapamil
☐ Diltiazem
☐ Nimodipin

Anticonvulsants:
☐ Depakote
☐ Depakote ER
☐ Neurontin
☐ Gabitril
☐ Topamax

Other:
☐ Cyroheptadine
☐ Sansert
☐ Estradiol
☐ Feverfew
☐ Vitamin B12
☐ D.H.E.A
☐ 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 NeuroCare Center, Inc. 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 of Patient ______________________________________________ Date ___________________________