

## HEADACHE HISTORY & PROFILE

NAME

DATE OF BIRTH

TODAY'S DATE

Where are your headaches located? On what part of the head do the headaches start?

(R) Side     (L) Side     Either side     Both sides  
 Back     On top     Temples     Behind / around eyes  
 Forehead     Face     Neck     Other –

After the headache starts – Does it usually – Stay in one place     Move around     Please explain –

How would you describe the pain? -     Throbbing / pulsating     Pressing / squeezing     Stabbing     Sharp  
 Dull / nagging     Other –

Describe the degree of pain (circle one #) – slight – 1 2 3 4 5 6 7 8 9 10 – worst imaginable

Do your headaches interfere or prevent normal activities – school, work, etc.?  No     Yes, If so how many days have been missed?

How long ago did the current headache start?     Weeks     Months     Years

How old were you when any headache started? \_\_\_\_\_

How long does the headache usually last?     Minutes     Hours     Days     Constant

How often does the headache occur?     x / Day     x / Week     x / Month     x / Year     Constant

Does the headache awaken you from sleep?  Yes     No

Is the headache getting     worse     better     fluctuating     no change

Are any of the following symptoms associated with the headache? Please mark (B) before (✓) during (A) after

<input type="checkbox"/> Spots before eyes – type – <input type="checkbox"/> Blindness (R L) <input type="checkbox"/> Blurring (R L) <input type="checkbox"/> Double vision <input type="checkbox"/> Can see only half of objects <input type="checkbox"/> Eyelid droop (R L) <input type="checkbox"/> Tearing (R L) <input type="checkbox"/> Eye redness (R L) <input type="checkbox"/> Eyes puffy (R L) <input type="checkbox"/> Light sensitivity <input type="checkbox"/> Noise sensitivity <input type="checkbox"/> Odors sensitivity <input type="checkbox"/> Nose blocked / discharge (R L)	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Hunger <input type="checkbox"/> Cramps <input type="checkbox"/> Diarrhea <b>Face – Scalp –</b> <input type="checkbox"/> Pale <input type="checkbox"/> Redness <input type="checkbox"/> Sweating <input type="checkbox"/> Tender <input type="checkbox"/> Puffy <input type="checkbox"/> Pain on chewing <input type="checkbox"/> Decreased jaw opening <b>Neck -</b> <input type="checkbox"/> Stiff <input type="checkbox"/> Tender <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Fatigue <input type="checkbox"/> Irritability	<b>Weakness (W) Numbness (N) Both (B)</b> <input type="checkbox"/> Face (R L) <input type="checkbox"/> Arms (R L) <input type="checkbox"/> Arm & leg (R L) <input type="checkbox"/> Legs (R L) <input type="checkbox"/> Difficulty talking (finding words) <input type="checkbox"/> Difficulty understanding <input type="checkbox"/> Numbness around lips <input type="checkbox"/> Slurred speech <input type="checkbox"/> Fainting (feel like or have fainted) <input type="checkbox"/> Dizzy (lightheaded – unsteady – spinning) <b>Hands and / or feet –</b> <input type="checkbox"/> Cold <input type="checkbox"/> Pale <input type="checkbox"/> Sweaty <input type="checkbox"/> Mottled
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## HEADACHE HISTORY & PROFILE (continued)

Indicate if any of the following factors have (✓) brought on (trigger) or (x) worsened your headache –

Head injury

Sleep-too much-too little

Emotional stress  during  after

Depression – anxiety

Physical activity

Sitting up

Bending over

Straining – coughing

Missed meal

Change in weather

Seasons –

Allergies  MSG

Processed meats

Chocolate  Citrus Fruits

Cheeses

Caffeine

Other foods

Medications

Menstrual periods

Other \_\_\_\_\_

Do any blood relatives have severe headaches?  No  Yes Who & Diagnosis -

Which of the following makes the headache better?  Rest  Activity  Darkness  Quiet  Compresses  Tylenol / Motrin

sleep

Scalp or temple pressure

Other \_\_\_\_\_

Have you been sad or worried about anything?

Previous professional treatment of headache?  No  Yes – Who & When –

Previous x-ray or other investigations of headache?  No  Yes – Describe –

Previous medications for headache?  No  Yes Name – dosage

Other current medications? Please list – include over the counter drugs

DRUG ALLERGIES

ADDITIONAL NOTES