Advanced Neurology OF COLORADO

HEADACHE HISTORY & PROFILE QUESTIONNAIRE

Patient Name: _____

On what part of the head do your headaches start?

_____ R Side	_____ L Side	_____ Either Side	_____ Both Sides
_____ Back	_____ On Top	_____ Temples	_____Behind/AroundEyes
_____ Forehead	_____ Face	_____ Neck	_____ Other

How long ago did you current headache start?
_____ Days _____ Weeks _____ Months _____ Years

How old were you when your headaches started? _____

How long do your headaches usually last?
_____ Minutes _____ Hours _____ Days _____ Constant

How often do your headaches occur?
_____ x/Day _____ x/Week _____ x/Month _____x/Year _____ Constant

Is the headache getting - _____ More Severe _____ More Frequent _____ Both

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 when your headaches start:
Slight 1 2 3 4 5 6 7 8 9 10 Worse Imaginable

Describe the degree of pain with most of your headaches:
Slight 1 2 3 4 5 6 7 8 9 10 Worse Imaginable

Describe the degree of pain with your worst headaches:
Slight 1 2 3 4 5 6 7 8 9 10 Worse Imaginable

Do your headaches interfere or prevent normal activities? Work, school, etc … Yes No

Has your productivity at work or school been affected by your headaches? Yes No

In the **last month** have your headaches caused you to miss: Leisure/Social/Work/School? Yes No

In the **last 6 months** have your headaches caused you to miss: Leisure/Social/Work/School? Yes No

Do any of your blood relatives have severe headaches? Yes No If yes, who? _____

Do you have a history of head or neck injury? Yes No

If yes, did it involve loss of consciousness? Yes No

Which of the following makes the headache better? ___ Rest ___ Activity ___ Darkness ___ Quiet
___ Hot Compress ___ Cold Compress ___ Pregnancy ___ Menopause ___ Scalp/Temple Pressure

LIFESTYLE:

Do you exercise regularly? Yes No If yes, how often? _____

Do you frequently skip meals? Yes No

How much caffeine do you eat/drink in a day? _____
(Coffee, tea, soda, chocolate etc)

Do you smoke cigarettes? Yes No If yes, how many per day? _____
How long have your smoked? _____

Do you drink alcohol? Yes No If yes, how many oz per day? _____

Do you drink coffee/tea? Yes No If yes, how many cups per day? _____

Do you have a problem sleeping? Yes No

Do your headaches wake you up? Yes No

Do you wake feeling rested? Yes No

Are you or have your been: _____ Depressed _____ Anxious

ASSOCIATED HEADACHE SYMPTOMS:

Are any of the following symptoms associated with your headaches? Please mark (B) before (D) during (A) after

____ Spots before eyes/type ____ Blindness (R/L) ____ Blurring (R/L) ____ Eyelid Droop (R/L)
____ Can see only ½ of objects ____ Tearing ____ Double Vision ____ Eye Redness (R/L)
____ Puffy Eyes (R/L) ____ Light Sensitivity ____ Noise Sensitivity ____ Odor Sensitivity
____ Stuffy Nose ____ Runny Nose

ABDOMINAL:

____ Nausea ____ Vomiting ____ Stomach Cramps ____ Hunger ____ Loss of Appetite
____ Diarrhea

FACE/SCALP:

____ Pale ____ Redness ____ Sweating ____ Tender ____ Pain while Chewing
____ Puffy ____ Decreased Jaw Opening

STATE OF MIND:

____ Depression ____ Fatigue ____ Anxiety ____ Irritability ____ Difficulty Concentrating
____ Difficulty Talking (finding words) ____ Difficulty Understanding ____ Dizzy
____ Fainting (feeling like or actuality)

HANDS AND/OR FEET:

____ Cold ____ Pale ____ Sweaty ____ Mottled

WEAKNESS (W) NUMBNESS (N) BOTH (B)

____ Face (R/L) ____ Arms (R/L) ____ Legs (R/L) ____ Arm & Leg (R/L)

Indicate if any of the following factors have: (+) brought on a headache or (++) worsen your headaches

____ Sleep too much/too little ____ Sexual Activity ____ Chocolate ____ Emotional Stress
____ Medications (include over the counter/supplements) ____ Missed Meals ____ Citrus Fruit
____ Menstrual periods ____ Depression/anxiety ____ Change in weather ____ Chesses
____ Pregnancy ____ Physical activity ____ Seasons ____ MSG ____ Menopause
____ Erect position ____ Alcohol ____ Other foods (list) ____ Oral contraceptives ___ Bending
____ Process meat ____ Straining ____ Coughing ____ Over eating ____ Dehydration
____ Too much caffeine ____ Infections ____ Relief of stress ____ High altitude ____ Head injury
____ Driving at night ____ Bright lights, Loud sounds, Strong smells

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IN ADDITION TO THE ABOVE LISTED MEDICATIONS, WHICH OF THE FOLLOWING HAVE YOU USED FOR TREATMENT OF YOUR HEADACHES?

THERAPY	NEVER USED	PRESENTLY USING	TRIED IN THE PAST	EFFECT ON HEADACHE WORSE/IMPROVED UNCHANGED/DON'T KNOW
ACUPUNCTURE				
BIOFEEDBACK				
AROMATHERAPY				
CHIROPTACTIC TREATMENT				
RELAXATION THERAPY				
COGNITIVE THERAPY/PSYCHOTHERAPY				
REFLEXOLOGY				
MASSAGE				
AVOIDNESS OF FOODS AND/OR DRINKS THAT TRIGGER HEADACHE				
AVOIDNESS OF ACTIVITIES THAT TRIGGER HEADACHES				
OTHER				
OTHER				
OTHER				
OTHER				