Intake Form: Headache

Chief Complaint

In your own words, what brings you in today?

_____

_____

History of Present Illness (HPI)

Briefly describe your present symptoms:

_____

_____

Date symptoms began? _____

Describe the frequency of the problem *(continuous, intermittent, daily, hourly etc.)*:

_____

On a scale from 0 to 10, 0 being no problem at all and 10 being severe as possible, how would you rate it? _____

What body parts are most affected? _____

Have you previously received a diagnosis for this problem? *(circle one)* **Yes** **No**

If so, what was the diagnosis:_____

Who made the diagnosis:_____

What tests have been performed to evaluate this problem *(i.e. MRI, lab tests, etc.)*?

_____

_____

What treatments have been tried for this problem *(i.e. medications, physical therapy, etc.)*?

_____

_____

What improves the problem *(medication, rest, sitting, etc.)*?

_____

_____

What worsens the problem *(exercise, poor sleep, stress, etc.)*?

_____

_____

Has your problem interfered with your activities of daily living, such as bathing, feeding, or clothing yourself, or has it impacted your occupation? If so, what?

_____

_____

Who in your family has a similar problem?

_____

Are you interested in participating in research trials? *(circle one)* **Yes** **No** **Maybe**

Surgical History ☐ No prior surgeries or procedures

Procedure	Date (MM/YYYY)	Complications?

Review of Systems

Constitutional ☐ None of the below

☐ Fever / Chills
☐ Unintentional weight gain / loss
☐ Exercise intolerance
☐ Fatigue
☐ Night sweats
☐ Inability to sleep
☐ Sleeping too much

HEENT ☐ None of the below

☐ Blurred vision / vision loss
☐ Hearing change
☐ Nosebleeds
☐ Difficulty chewing / swallowing
☐ Change in smell / taste
☐ Double vision
☐ Ringing in the ears
☐ Hoarseness / prolonged sore throat
☐ Speech changes / difficulty
☐ Snoring

Respiratory ☐ None of the below

☐ Shortness of breath
☐ Wheezing
☐ Chronic cough

Cardiovascular ☐ None of the below

☐ Chest pain / pressure / heaviness
☐ Swelling of feet / ankles
☐ Palpitations
☐ Fainting spells

Gastrointestinal ☐ None of the below

☐ Nausea / Vomiting
☐ Constipation
☐ Diarrhea
☐ Heartburn / Indigestion
☐ Abdominal pain
☐ Blood in stool

Genitourinary ☐ None of the below

☐ Pain or burning with urination
☐ Blood in urine
☐ Sexual dysfunction / impotence
☐ Frequent urination
☐ Change in menstrual cycle

Neurologic ☐ None of the below

☐ Headache
☐ Numbness / Tingling
☐ Involuntary movements / tremor / twitching / cramps
☐ Memory loss
☐ Poor balance / falls
☐ Seizures / Convulsions

Psychiatric ☐ None of the below

☐ Mood change
☐ Depression
☐ Anxiety
☐ Hallucinations
☐ Paranoia
☐ Delusions

Endocrine ☐ None of the below

☐ Heat or cold intolerance
☐ Excessive sweating
☐ Excessive thirst / urination
☐ Hair change

Hematologic/Immune ☐ None of the below

☐ Easy bruising or bleeding
☐ Swollen lymph nodes

Musculoskeletal ☐ None of the below

☐ Joint pain
☐ Neck pain +/- shooting pain into arms
☐ Low-back pain +/- shooting pain into legs

Headache Questionnaire

My headaches started on: _____

I get headaches about every: _____day_____days per week_____days per month

My headaches are accompanied by: *check if 'yes'*

□ Light sensitivity	□ Visual changes	□ Confusion	□ Dizziness
□ Noise sensitivity	□ Numbness	□ Loss of consciousness	□ Congestion
□ Nausea	□ Weakness	□ Red / tearing eyes	□ Vomiting

History of Preventative Medications

Medications taken regularly to prevent headaches.

Medication	Currently taking? (Y/N)	Did it help? (Y/N)	Maximum dose, duration used, and side effects
Beta Blockers (propranolol, metoprolol, etc.)			
Verapamil			
Amitriptyline (Elavil)			
Nortriptyline (Pamelor)			
Valproic acid (Depakote)			
Topimarate (Topamax)			
Pregabalin (Lyrica)			
Erenumab (Aimovig)			
Fremanezumab (Ajovy)			
Eptinezumab (Vyepti)			
Galcanezumab (Emgality)			
Atogepant (Qulipta)			
Rimegepant (Nurtec ODT)			
Botox Injections			
Butterbur			
Magnesium			
Other			

History of Abortive Medications

Medications taken as needed to get rid of headaches.

Medication	Currently taking? (Y/N)	Did it help? (Y/N)	Maximum dose, duration used, and side effects
Acetaminophen (Tylenol)			
Ibuprofen (Advil)			
Excedrin Migraine			
Naproxen (Aleve)			
Epidrin (Midrin)			
Cafergot			
Fioricet (Fiorinal)			
Dihydroergotamine (Migranal)			
Triptans (circle): Maxalt, Imitrex, Relpax, Amerge			

Narcotics (circle): Percocet, Vicodin, Lortab, Fentanyl			
Steroids			
Ubrogepart (Ubrelvy)			
Other			
Acetaminophen (Tylenol)			
Ibuprofen (Advil)			
Excedrin Migraine			
Naproxen (Aleve)			

Have you tried any of the following preventative procedures for headaches?

Procedure	Currently doing? (Y/N)	Did it help? (Y/N)
Trigger Point Injections		
Chiropractic Manipulation		
Physical Therapy		