Headache Questionnaire

This headache questionnaire is crucial to help us understand you and give you the best care.

By completing it, you maximize your time with us at Center for Healing Neurology. This lets us focus on providing an accurate diagnosis and developing the best treatment plan for you.

Please fill out this form to the best of your knowledge: if you aren’t completely sure about an answer, give the answer you think is most correct.

Feel free to fill this out with the help of your family and other healthcare providers.

This completed form is required in order to attend our Headache Clinic.

First Name: ________________________  Last Name: ________________________

Date of Birth: ___ / ___ / ______ (Mo/Day/Year)

What goals are important for you to discuss during this visit? Select all that apply.

☐ Understand why I am having pain
☐ Better understand my current diagnosis
☐ Discuss headache treatment
☐ I am worried that I might have a brain tumor
☐ I am worried about having other disease
☐ I have a specific treatment I would like to ask about
☐ Other _____________________________

What treatment options do you prefer? Please select all that apply.

☐ Preventive prescription medication
☐ Acute prescription medication
☐ Supplements, herbs, or vitamins
☐ BOTOX
☐ Other non-medication procedures (e.g. nerve blocks)
☐ Biofeedback or meditation
☐ Hypnosis
☐ Stress management
☐ Other _____________________________
If you have multiple types of headaches: Please answer the following questions regarding the headache that concerns you most.

What is most concerning to you about your headache(s)?
Check all that apply.

☐ My headaches have increased in severity
☐ My headaches have increased in frequency
☐ I am concerned about visual changes
☐ I am concerned about numbness associated with the headaches
☐ I am concerned about weakness in arm(s) or leg(s) associated with the headaches
☐ I have new non-headache symptoms such as dizziness and vertigo
☐ I have been having problems with my memory
☐ I don’t know
☐ Other ________________________________

Have you been given a specific headache diagnosis from another provider?
Yes ☐ No ☐

Have you had any history of head trauma (such as concussion, head injury)?
Yes ☐ No ☐

Have you ever been diagnosed with an autoimmune disease (such as rheumatoid arthritis, lupus, etc), cancer or experienced a bone marrow or organ transplant?
Yes ☐ No ☐
Headache Questionnaire

HEADACHE DETAILS

Please provide a brief description of your headache or headache related symptoms that you want us to evaluate (vertigo, visual loss or other).

How long ago did your headache(s) become a problem?
☐ less than 1 year ago
☐ 1 to 3 years ago
☐ 3 to 5 years ago
☐ 5 to 10 years ago
☐ longer than 10 years ago

Do you have headache 15 days a month or more? (This includes any headache combination such as having migraines 8 days per month and having tension headache the rest of the days)
Yes ☐ No ☐

How many days per month are you having any headache? __________

How many days per month are you having severe headaches? __________

Do you ever have time(s) with no headache-related pain (even a few minutes with no headache during the day)? Yes ☐ No ☐

What is the average severity of your headaches on a scale of 0-10, where 1 means "almost no pain" and 10 means "the worst headache or pain imaginable"?
☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7  ☐ 8  ☐ 9  ☐ 10

What is the worst severity of your headaches on a scale of 0-10, where 1 means "almost no pain" and 10 means "the worst pain imaginable"?
☐ 0  ☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  ☐ 6  ☐ 7  ☐ 8  ☐ 9  ☐ 10

Which of these amounts of time best describes how long your headaches usually last?
☐ seconds  ☐ minutes  ☐ hours  ☐ days
When in the day do your headaches usually occur? (morning, evening, etc.)
Please select all that apply.
☐ all day long  ☐ morning  ☐ mid-day  ☐ afternoon  ☐ evening
☐ wake me up from sleep  ☐ no specific time

What is the best description of your headache?
Please select all that apply.
☐ pulsing or throbbing  ☐ pressure  ☐ tension  ☐ sharp  ☐ stabbing  ☐ dull
☐ burning  ☐ other ______________

Where are the headaches that concern you most located? Please select all that apply.
☐ eye  ☐ forehead  ☐ temple  ☐ face  ☐ back of the head  ☐ neck  ☐ all over
☐ other ______________

On which side does the headache pain occur? Please select all that apply
☐ right side  ☐ left side  ☐ both side  ☐ always on one side  ☐ changes sides

Do you have any changes in vision before or during migraine? Please check all that apply.
☐ seeing zigzag lines
☐ temporary blind spot (scotoma)
☐ blurred vision
☐ seeing visual hallucinations
☐ seeing bright lights
☐ temporary double vision
☐ seeing heat waves
☐ other ______________
# Headache Questionnaire

## Headache Triggers and Associated Factors

Do you have any headache triggers? Please check all that apply.

- [ ] stress
- [ ] menstrual period
- [ ] change in sleep
- [ ] skipped meals, thirst or dehydration
- [ ] food: cheese, chocolate, MSG, other
- [ ] alcohol (for example, red wine)
- [ ] exercise and physical exertion
- [ ] mental exertion (like solving a math problem)
- [ ] change in weather
- [ ] environment over-stimulation: glare, odors and other
- [ ] I don’t know
- [ ] other

What makes your headaches worse? Select all that apply.

- [ ] bright light or glare
- [ ] loud sounds
- [ ] strong smells
- [ ] physical exertion
- [ ] mental exertion
- [ ] being at work
- [ ] nothing makes the headache worse
- [ ] eye strain
- [ ] computer work

Do you have any other symptoms before or during the headache?

- [ ] I have no other symptoms
- [ ] nausea/vomiting
- [ ] light sensitivity
- [ ] sound sensitivity
- [ ] numbness
- [ ] weakness
- [ ] dizziness
- [ ] fatigue/low energy
- [ ] neck stiffness or tenderness
- [ ] eye tearing on the side of headache
- [ ] nasal congestion during headache
- [ ] eye redness during headache
- [ ] other _____________________
Headache Questionnaire

**ACTIONS THAT PROVIDE HEADACHE RELIEF**

Do any of the following help relieve your headache(s)? Please select all that apply.

- [ ] nothing helps
- [ ] medications
- [ ] exercise
- [ ] sleep (at night or nap)
- [ ] rest
- [ ] avoiding bright lights, loud sounds, certain smells
- [ ] avoiding foods that can cause headache
- [ ] drinking water
- [ ] staying at home and not working
- [ ] other_________________


**Headache Questionnaire**

**MEDICATION HISTORY/HEADACHE TREATMENT**

The following questions are about your medication history. Please answer them to the best of your ability.

**Medication(s) to STOP headache**

Do you take medication(s) to stop headache? Yes ☐  No ☐

If yes, which medications?

<table>
<thead>
<tr>
<th>Medication(s)</th>
<th>Currently taking (more than 4 days a month)</th>
<th>Currently taking (less than 4 days a month)</th>
<th>Taken in the past</th>
<th>Side effect(s)</th>
<th>Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Acetaminophen (Tylenol)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐ Ibuprofen (Motrin/Advil)</td>
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<td>☐ Naproxen (Aleve/Naprosyn)</td>
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<td>☐ Aspirin</td>
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<td>☐</td>
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<tr>
<td>☐ Ketorolac (Toradol/Sprix)</td>
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<td>☐ Ketoprofen (Relafen)</td>
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<td>☐ Diclofenac (Cambia)</td>
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<td>☐ Celebrex(Celecoxib)</td>
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<td>☐ Excedrin</td>
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<tr>
<td>☐ Butalbital(Fioricet or Fiorinal)</td>
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<td>☐ Midrin</td>
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<tr>
<td>☐ Methylprednisolone (Medrol Pack)</td>
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<tr>
<td>☐ Prednisone/Prednisolone</td>
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<tr>
<td>☐ Sumatriptan (Imitrex/Treximet)</td>
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<tr>
<td>☐ Rizatriptan(Maxalt)</td>
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<tr>
<td>☐ Naratriptan(Amerge)</td>
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<tr>
<td>☐ Almotriptan(Axert)</td>
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<tr>
<td>☐ Frovatriptan(Frova)</td>
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<tr>
<th>Medication(s) to STOP headache.</th>
<th>Currently taking (more than 4 days a month)</th>
<th>Currently taking (less than 4 days a month)</th>
<th>Taken in the past</th>
<th>Side effect(s)</th>
<th>Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eletriptan(Relpax)</td>
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<tr>
<td>Zolmitriptan(Zomig)</td>
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<td>Metoclopramide(Reglan)</td>
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<td>Prochlorperazine(Compazine)</td>
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<tr>
<td>Promethazine (Phenergan)</td>
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<tr>
<td>Ondansetron(Zofran)</td>
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<tr>
<td>Diphenhydramine(Benadryl)</td>
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<td>DHE(Migranal)</td>
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<td>Tramadol(Ultram/Ultrace)</td>
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<tr>
<td>Tylenol #3/Tylenol with Codeine</td>
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<td>Morphine</td>
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<tr>
<td>Dilaudid (Hydromorphone)</td>
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<td>Vicodin</td>
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<tr>
<td>Marijuana</td>
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<td>Other</td>
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<tr>
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</tbody>
</table>
List medications that you are taking (or have taken in the past) to prevent headache or migraine from occurring.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Currently Taking</th>
<th>Helpful</th>
<th>Not Helpful</th>
<th>Caused Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inderal (Propanolol)</td>
<td>☐</td>
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<tr>
<td>Depakote (Valproate)</td>
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<tr>
<td>Topamax (Topiramate)</td>
<td>☐</td>
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<tr>
<td>Neurontin (Gabapentin)</td>
<td>☐</td>
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<tr>
<td>Lyrica (Pregabalin)</td>
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<tr>
<td>Elavil (Amitriptyline)</td>
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<tr>
<td>Cyt RXa (Citalopram)</td>
<td>☐</td>
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<tr>
<td>Cymbalga (Duloxetine)</td>
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<tr>
<td>Verapamil</td>
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<tr>
<td>Levetiracetam (Keppra)</td>
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<tr>
<td>Lamotrigine (Lamictal)</td>
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<tr>
<td>Zonisamide (Zonegram)</td>
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<tr>
<td>Nortriptyline (Pametor)</td>
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<tr>
<td>Fluoxetine (Prozac)</td>
<td>☐</td>
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<tr>
<td>Sertraline (Zoloft)</td>
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<tr>
<td>Venlafaxine (Effexor)</td>
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<tr>
<td>Cyproheptadine (Periactin)</td>
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<td>Metoprolol (Toprol)</td>
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<tr>
<td>Lisinopril (Zestril)</td>
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<tr>
<td>Acetazolamide (Diamox)</td>
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<tr>
<td>Doxycycline</td>
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</tbody>
</table>

Continued on next page
Headache Questionnaire

[CONTINUED from Previous Page]
List medications that you are taking (or have taken in the past) to prevent headache or migraine from occurring.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Currently Taking</th>
<th>Helpful</th>
<th>Not Helpful</th>
<th>Caused Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minocycline</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>BOTOX (onabotulinum toxin) for migraine</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Occipital nerve block</td>
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<tr>
<td>CEFALY</td>
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<tr>
<td>Marijuana daily for headache prevention</td>
<td>☐</td>
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<tr>
<td>Other:</td>
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<td>None</td>
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</tbody>
</table>
**Headache Questionnaire**

Please let us know what other therapies you have tried or are currently using for headache management. Check all that apply.

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Currently</th>
<th>In the past</th>
<th>Helpful</th>
<th>Not Helpful</th>
<th>Side effect(s)</th>
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<tbody>
<tr>
<td>Physical Therapy</td>
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<td>Massage Therapy</td>
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<td>Acupuncture</td>
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<td>Biofeedback</td>
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<td>Meditation</td>
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<td>Cefaly Device</td>
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<td>Diet</td>
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<td>Exercise</td>
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</tbody>
</table>
Headache Questionnaire

**What supplements are you currently taking or have you taken in the past for your headaches?**

<table>
<thead>
<tr>
<th>Supplement</th>
<th>Currently</th>
<th>In the past</th>
<th>Helpful</th>
<th>Not Helpful</th>
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<tr>
<td>Magnesium</td>
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<tr>
<td>Riboflavin (Vitamin B2)</td>
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<tr>
<td>Vitamin B12</td>
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<td>Vitamin B Complex</td>
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<td>Melatonin</td>
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<td>Turmeric</td>
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<td>Marijuana</td>
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<td>Other</td>
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<td>None</td>
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Have you ever gone to an emergency room for treatment of a headache?  
Yes [ ]  No [ ]

Have you ever had a CT/CAT(Computed tomography) scan of the brain?  
Yes [ ]  No [ ]

Have you ever had an MRI (Magnetic Resonance Imaging) scan of the brain?  
Yes [ ]  No [ ]
Headache Questionnaire

**GENERAL HEALTH**

In general your health is:
- □ excellent
- □ very good
- □ good
- □ fair
- □ poor

Does your headache limit you in the following activities?
- □ Vigorous activities (running, lifting heavy objects, participating in sports)
- □ Moderate activities (moving table, pushing a vacuum, playing golf)
- □ Lifting or carrying groceries
- □ Climbing several flights of stairs
- □ Climbing one flight of stairs
- □ Bending, kneeling, or stooping
- □ Walking more than one mile
- □ Walking several blocks
- □ Walking one block
- □ Bathing or dressing yourself
- □ Does not interfere with any of these activities

In the past 3 months, how much did your headache(s) interfere with your normal work (outside and housework)?
- □ not at all
- □ a little bit
- □ moderately
- □ quite a bit
- □ extremely

Do you get at least 7 hours of sleep per night most nights? Yes □ No □

Do you have any difficulty with sleep? Yes □ No □

Do you have depression or anxiety? Yes □ No □
**OTHER HEALTH ISSUES AND FAMILY HISTORY**

Have you been diagnosed with any of the following conditions?

- [ ] I do not have any other health conditions
- [ ] High blood pressure (hypertension)
- [ ] Sleep apnea
- [ ] High cholesterol (high fat or high lipids)
- [ ] Heart attack
- [ ] Arrhythmia
- [ ] Other heart disease (if yes, specify what type)
- [ ] Hypothyroidism
- [ ] Stroke or TIA
- [ ] Seizures or epilepsy
- [ ] Fibromyalgia
- [ ] Chronic fatigue syndrome
- [ ] Depression
- [ ] Bipolar disorder
- [ ] Anxiety or panic disorder
- [ ] PTSD
- [ ] Other

Have you had any surgeries in the past? Select all that apply.

- [ ] I have never had surgery in the past
- [ ] Spine surgery
- [ ] Brain surgery
- [ ] Appendectomy
- [ ] Gallbladder surgery
- [ ] Other

Did any of the following family members develop heart disease?
Check all that apply.

- [ ] **Before age 55**: father, brother, son  
- [ ] None before age 55  
- [ ] Don’t know

- [ ] **Before age 60**: mother, sister, daughter  
- [ ] None before age 60  
- [ ] Don’t know
Headache Questionnaire

OTHER HEALTH ISSUES AND FAMILY HISTORY – Continued

Does/did anyone in your family have any of the following disorders? This includes grandparents, uncles, aunts, parents, siblings, cousins, and children.

<table>
<thead>
<tr>
<th></th>
<th>Headache</th>
<th>Seizures</th>
<th>Dementia</th>
<th>Stroke</th>
<th>Aneurysm</th>
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Headache Questionnaire

SOCIAL HISTORY

The following questions pertain to your social history and help us get to know you better. Please fill them out to the best of your ability.

What is the highest degree or level of school you have completed?
- no schooling completed
- some high school, no diploma
- finished high school
- some college, no degree
- finished college or university
- some graduate work
- Masters
- Doctorate
- Other ________________

Are you currently employed? Yes ☐ No ☐

How many minutes per week do you get of moderate or vigorous exercise? (This includes very brisk walking, jogging, playing a sport, heavy cleaning, bicycling, and so on.)

How many servings of wheat, potatoes, rice, or bread do you eat per day? This includes products such as bread and potato chips.

How many servings of fruit and vegetables do you eat per day? This does not include products made with fruit or vegetables, such as fruit jam or pie.
Headache Questionnaire

SOCIAL HISTORY – Continued

Do you smoke or use tobacco products? Yes ☐ No ☐

Do you consume alcoholic beverages? Yes ☐ No ☐

Do you consume caffeinated beverages? This includes coffee, tea, energy drinks, and certain sodas. Yes ☐ No ☐

Do you use recreational or street drugs? This includes drugs such as marijuana, cocaine, heroin and meth, and others. Yes ☐ No ☐
Headache Questionnaire

**OTHER SYMPTOMS**

The following questions pertain to other symptoms. Some may pertain to headache, some may not, but all help us to make sure we do not miss any possible diagnosis to help you heal.

Please check any of the symptoms that you are currently experiencing or symptoms you may experience during headache.

- □ Dizziness
- □ Headache
- □ Light-headedness
- □ Numbness
- □ Seizure
- □ Difficulty speaking
- □ Fainting
- □ Muscle weakness (not fatigue)
- □ Tremor

Choose any of the following symptoms you are currently or recently experiencing:

- □ Confusion
- □ Decreased ability to concentrate
- □ Depressed mood
- □ Anxious mood
- □ Trouble sleeping
- □ Thoughts of harming yourself or others

Do you have any symptoms related to your eyes such as visual loss, redness of eyes, or visual blurring? Yes □ No □

Do you have any symptoms related to your ears, nose or throat? Yes □ No □

Are you having any problems with your heart or circulation such as chest pain? Yes □ No □

Are you having any difficulty with your lungs or with breathing such as shortness of breath, COPD or chronic cough? Yes □ No □
OTHER PROVIDERS

This section asks for information regarding the other providers that are involved in your care.

What is the name of your primary care provider (PCP)?
Answer "none" if you have no PCP.

Are there any other providers who need to receive a medical report from our clinic?
If so, please provide their names, phone numbers, and addresses. Can answer "none" if there are no providers who need reports.

Have you already seen any neurologist for management of your headache?
Yes ☐ No ☐

Have you seen any healthcare providers for management of your headache that are not neurologists?
Yes ☐ No ☐