ASSOCIATED NEUROLOGICAL SPECIALTIES

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CHIEF COMPLAINT-HEADACHE

Patient Name:_____ Today's Date:_____

1. When did you start having headaches? Did you have headaches in childhood?

2. Where are your headaches located?

3. Please describe what type of pain you have (throbbing, stabbing, aching).

4. How often do you have headaches?

5. Do you have more than one type of headache?

6. How long do they last?

7. Do you have nausea and vomiting associated with the headaches?

8. Do you have any visual disturbances?

9. What time of day do your headaches usually occur?

10. What medications have you tried before for your headaches?

CHIEF COMPLAINT-HEADACHE CONTINUED:

11. Have you had an MRI or CT scan done? When?

12. Do you have a family history of headaches?

13. Are your headaches moderate to severe in intensity?

14. Did you suffer from carsickness as a child?

Patient Name:_____ Date of Birth:_____

Today's Date:_____ Diagnosis:_____

MIGRAINE QUESTIONNAIRE

Directions: Please circle yes to any questions that seem to pertain to your headaches. Skip the question if the answer is no.

	M	TT	C	O	
1. Did this same headache ever occur before?	yes				
2. Do you have more than one type of headache?	yes				
3. Do your headaches usually occur during daytime hours?	yes				
4. Does your mother, father, siblings, children or any blood relative have similar headaches? (Answer NA if adopted.)	yes				
5. Do you have any changes in vision (flashing lights, blurred vision, or spots) before or during a headache?	yes				
6. Does your headache pain throb or pound?	yes				
7. Do your headaches occur during weekends or holidays?	yes				
8. Do alcoholic drinks cause or aggravate your headaches?	yes				
9. Does chocolate, cheese, milk, nuts, Chinese food, or any food cause or worsen your headache?	yes				
10. Have you noticed any paralysis, muscle weakness, swallowing problems or speech changes during your headaches?	yes				
11. Would you describe your headache as moderate to severe in intensity?	yes				
12. Does your headache ever require you to lie down?	yes				
13. Do you prefer a dark, quiet room when you have a headache?	yes				
14. Do you ever miss work (or school) because of headaches?	yes				
15. Do you see zig zag lines before a headache?	yes				
16. Does your headache last between 1 to 3 days?	yes				
17. Is your headache unresponsive to plain aspirin or Tylenol?	yes				
18. Do bright lights or sunshine cause your bad headaches?	yes				
19. Does a change in barometric pressure, or storms ever trigger your headache?	yes				
20. Does a change in your sleep schedule trigger your headache?	yes				
21. Does your headache pain feel as if your heart is beating in your head?	yes				
22. Did your headaches begin in adolescence or early adulthood?	yes				
23. Do you ever feel tired prior to a headache starting?	yes				
24. Do you ever have excessive thirst/hunger prior to a headache?	yes				
25. Do odors such as perfumes or gasoline fumes ever trigger a headache?	yes				
26. Do you feel drained or "worn-out" the day after a headache?	yes				
27. Did you ever suffer from motion sickness as a child?	yes				

28. Do you lose your appetite with a headache?	yes				

29. Do you ever feel lightheaded or off-balance with a headache?	yes				
30. Do you ever experience difficulty thinking or speaking clearly with a headache?	yes				
31. Do you ever have diarrhea after a headache?	yes				
32. Does constipation ever seem to trigger your headache?	yes				
33. Is it difficult to read during a headache?	yes				
34. Will watching TV aggravate a headache?	yes				
35. Is your headache pain dull and steady, like an intense constant pressure?		yes			
36. Do you usually have more than 5 headaches per week?		yes			
37. Do your headaches usually occur during the night?			yes		
38. Do you have watering of he eye on the affected side of the headache?			yes		
39. Do you get multiple headaches, which wake you, during the night?			yes		
40. Would you describe your headache pain as a red, hot poker in your eye?			yes		
41. Would you describe your headaches a s a squeezing or vise-like sensation?		yes			
42. Do you always have a headache (daily headache)?		yes			
43. Does coughing or sneezing ever start a headache?				yes	
44. Do you tend to pace the floors with a headache?			yes		
45. Do you get several very intense headaches daily, each lasting less than 5 minutes?				yes	
46. Are your headaches so excruciating that you have considered suicide?			yes		
47. Can you have 6-12 month periods when you experience NO headaches?			yes		
48. Is your headache less bothersome if you keep active at work or play?		yes			
49. Do your neck or shoulder muscles feel tight and painful during the headache?		yes			
50. Do you have frequent muscle and joint pain?		yes			
51. Have you been feeling down or depressed?		yes			
52. Have you noticed a decrease in your sexual desire or drive?		yes			
53. Do you often feel moody or easily irritated?		yes			
54. Have you noticed a general change/distortion in your perception of taste?				yes	

Use of Headache Questionnaire: Patient- circle the affirmative answers. Health care practitioner- look for trend toward a particular column.

M= Migraine TT= tension-Type C=Cluster O=Other/Organic

Patient Comfort Assessment Guide

Name:_____ Date:_____

1. Where is your pain?_____
2. Circle the words that describe your pain.

aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable
gnawing	tiring	unbearable

3. Circle One occasional continuous
4. What time of day is your pain the worst?
   morning afternoon evening nighttime
5. Rate your pain by circling the number that best describes your pain at its worst in the last month.
   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
6. Rate your pain by circling the number that best describes your pain at its least in the last month.
   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
7. Rate your pain by circling the number that best describes your pain on average in the last month.
   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
8. Rate your pain by circling the number that best describes your pain right now.
   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
9. What makes your pain better? _____
10. What makes your pain worse?_____
11. What treatments or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a)_____ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
Treatment or Medicine (include dose)

b)_____ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
Treatment or Medicine (include dose)

c)_____ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
Treatment or Medicine (include dose)

d)_____ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief

Treatment or Medicine (include dose)

10. What side effects or symptoms are you having? Circle the number that best describes your experience during the past week.

a. Nausea	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
b. Vomiting	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
c. Constipation	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
d. Lack of Appetite	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
e. Tired	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
f. Itching	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
g. Nightmares	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
h. Sweating	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
i. Difficulty Thinking	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
j. Insomnia	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine

11. Circle the one number that describes how during the past week pain has interfered with your:

a. General Activity	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
b. Mood	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
c. Normal Work	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
d. Sleep	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
e. Enjoyment of Life	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
f. Ability to Concentrate	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
g. Relations with Other People	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

Subject Name:_____Date:_____ Examiner:_____

1. Did the headaches start within 2 weeks of a head injury, trauma, or medical illness?
   YES NO (If No, proceed to next question)

2. Do you have any brain abnormality, like tumors or hydrocephalus?
   YES NO (If no, proceed to the next question)

3. Do you have a headache everyday or take over-the counter prescription pain or headache medications (e.g. Excedrin) more than 4 days per week?
   YES NO (If No, proceed to the next question)

4. Do you have an intermittent or constant headache?
   Constant Intermittent (If intermittent, proceed to the next question)

5. How long does each individual headache episode last?
   $<$ 2 Hours $\geq$ 2 Hours (If $\geq$ 2 hours, proceed to the next question)

6. Do you have **any** of the following neurological symptoms immediately before or during your headache episodes:
   ____Visual scotoma (blind or black spots in the vision)
   ____Visual hallucination (zigzag or wavy lines, colored lights or balls, shimmering patterns)
   ____Weakness or numbness on one side of your body
   If YES, diagnose MIGRAINE. No further questions needed. If NO, proceed with question 7.

7. Do you have at least **2** of the following symptoms with your headache?
   ____Pain is on one side of the head during a headache episode.
   ____Pain feels like throbbing or pulsing sensation
   ____Pain limits, restricts, or interferes with routine activities
   ____Pain is made worse by performing routine activities, such as stair climbing
   NO (STOP! No diagnosis of migraine) YES (If yes, proceed to next question)

8. Do you have at least **1** of the following symptoms with your headache?
   ____Nausea or vomiting
   ____Markedly increased sensitivity to **BOTH** normal lighting and **AND** conversational speech (You need to turn down or off the lights, close the curtains or blinds, turn down or off the radio or television, or need to retreat to a dark, quiet room)
   If YES, then diagnose MIGRAINE. If NO, no diagnosis of migraine.