Please complete the following if headache or head pain is the primary reason for today's evaluation

Patient name _____ ***DOB***_____
Date of office visit _____

Headache Characteristics

- Baseline headache intensity (0-10): _____

- Peak headache intensity (0-10): _____

- Headache frequency: _____

- Headache duration per episode: _____

- How quickly does your headache develop? i.e. instantly, seconds, minutes, hour(s) _____

- Have you ever gone to the emergency room to seek treatment for your headache? Yes / no

- What time of day (if any) is your headache at its worst? _____

- Are you awakened from sleep by your headache? Yes /no

- Do you feel agitated or the need to move during your headache? Yes / no

- Are your headaches made better or worse with the change of seasons? Yes /no
If yes, please describe _____

- Headache Location: please specify right (R), left (L) or both sides (B)

_____neck _____occipital (back of head) ____forehead _____temple _____eye _____top of head
_____cheek _____upper teeth _____lower teeth _____throat

- Headache quality: (please circle all that apply) constant intermittent pressure throbbing aching shooting electrical

- What makes your headache worse or triggers it? i.e. exercise, food groups, sound, bright lights, reading, odors, etc. _____

- What lessens your headache? i.e. sleep, rest, medications, dark room, etc. _____
_____

Patient name _____ ***DOB***_____

Headache associated symptoms

- Daily neck or occipital pain? Yes / no

  If yes, worsening neck pain with head movement? Yes / no

- Worsening headache with neck movement? Yes / no

- Aura with headache? Yes / no

- Nausea or Vomiting? Yes / no

- Light sensitivity? Yes / no

- Sound sensitivity? Yes / no

- Dizziness? Yes / no

- Loss of consciousness? Yes / no

- Loss of strength, sensation or tingling in arms or legs? Yes / no
  If yes, please describe_____

- Facial drooping? Yes / no
  If yes, please describe_____

- Drooping eye lid on side of headache? Yes / no

- Tearing on side of headache? Yes / no

- Bloodshot eye on side of headache? Yes / no

- Runny nose on side of headache? Yes / no

- Swelling around the eyes on side of headache? Yes / no

Please add any additional information regarding your headache:

_____
_____
_____
_____
_____