# COASTAL HEADACHE CLINIC

*Compassionate Headache and Migraine Care*

PHONE (910) 238-2050
FAX (910) 238-2310

1715-B COUNTRY CLUB RD
JACKSONVILLE, NC 28546

## HEADACHE ASSESSMENT FORM



| Name: | Date: |
|---|---|
| | |
| How old were you when your headaches started? | |
| Was there any specific event that occurred prior to the start? (head injury, illness, etc) If so, please explain: | |
| How many days per month do you experience headache pain? | |
| How many days per month is the headache / migraine pain severe? | |
| How long do the severe headaches / migraines last? (Please circle)<br>*Several hours* *one day* *two days* *three or more days* | |
| Please rate your severe headaches / migraines on a scale of 1-10 (with 10 being the most severe):<br>1 2 3 4 5 6 7 8 9 10 | |
| Where does the pain occur during your most severe headaches / migraines? (Please circle all that apply)<br>*Temple* *Frontal* *Top of head* *Back of head* *Neck* *Shoulders* | |
| Describe your headache pain: (Please circle all that apply)<br>*Throbbing* *Pulsing* *Squeezing* *Sharp* *Stabbing* *Dull* *Achy* | |
| Have your headaches changed in the past few months? (Please circle)<br>*Increased* *Decreased* *More severe* *Less severe* *New symptoms* | |
| Have your headaches changed in the past year? (Please circle)<br>*Increased* *Decreased* *More severe* *Less severe* *New symptoms* | |

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| |
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| Name: |
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| Do you often have nausea or vomiting with headaches / migraines? |
| Do you experience visual changes with headaches / migraines (such as flashing lights, dots in vision, loss of vision on one side or in peripheral, wavy lines, color changes) ? |
| Are you typically more sensitive to light? To sound? |
| If applicable, are your headaches worse before or during menses? |
| Are you currently (or have you recently been) prescribed oral birth control or hormone therapy? |
| Please circle any of the following that you feel may contribute to your headaches / migraines:<br><br>*Stress Stress release Weather changes Trigger foods Bright lights Loud noises Sexual activity Undersleeping Oversleeping Hormone changes Menses Exercise Exertion Skipped meals Dehydration Strong odors/perfumes Cigarette odor Alcohol* |
| Do you have any other medical problems such as high blood pressure, thyroid problems, sleep disorders, stomach problems or GI upset, heart disease, poor circulation, asthma or other breathing problems, memory changes, mood disorders, or others? |
| History of any surgeries: |
| Do you currently exercise? If so, what type and how often? |
| Do you smoke cigarettes? If so, how many per day and for how many years? |
| Do you drink alcohol? If so, how much and how often? |

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| |
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| Name: |
| |
| Do you have difficulty falling asleep? Staying asleep? Typical # of hours sleep _____ |
| Do you have a history of anxiety? If so, is it mild, moderate, or severe? |
| Do you have a history of depression? If so, is it mild, moderate, or severe? |
| |
| Have you seen other providers (neurologists, headache specialists, primary care doctors) regarding your headaches / migraines? |
| Have you had any imaging (MRI or CT Scan of head) and if so, when and what where results? |
| Have you had any bloodwork done in the past year, and if so, what were the results? |
| Please list ALL medications are you currently taking: |
| What medications have you tried in the past for headache / migraine treatment? |
| Please list ALL MEDICATION ALLERGIES: |