COASTAL HEADACHE CLINIC

Compassionate Headache and Migraine Care

HEADACHE ASSESSMENT FORM

Name:	**Date:**

How old were you when your headaches started?

Was there any specific event that occurred prior to the start? If so, please explain (head injury, illness, etc):

How many days per month do you experience headache pain? **(Please circle)**

1-4 days *5-10 days* *11-14 days* *15-20 days* *21 or more days*

How many days per month is the headache / migraine pain severe? (Please circle)

1-4 days *5-10 days* *11-14 days* *15-20 days* *21 or more days*

How long does each headache / migraine last? **(Please circle)**

4-24 hours *1-2 days* *3-4 days* *5 days or longer*

Where does the pain occur during most of your headaches / migraines?

(Please circle all that apply)

Temple *Frontal* *Top of head* *Back of head* *Neck* *Shoulders*

Right side of head *Left side of head* *Entire head*

Describe your headache pain: **(Please circle all that apply)**

Throbbing *Pulsing* *Squeezing* *Sharp* *Stabbing* *Dull* *Achy*

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Please circle any of the following that you feel may contribute to your headaches / migraines:

Stress *Stress release* *Weather changes* *Trigger foods* *Bright lights* *Loud noises*
Sexual activity *Undersleeping* *Oversleeping* *Hormone changes* *Exercise* *Alcohol*
Exertion *Skipped meals* *Dehydration* *Strong odors/perfumes* *Cigarette odor*

Have you found anything that helps decrease your migraines, and if so, what helps?

What are your goals for migraine treatment? **(Please circle all that apply)**

Less monthly migraine days	*Less acute medication use*	*Shorter duration of attacks*
Less missed work days	*Increase in family participation*	*Less "down time"*
Increase in social activities	*Increased focus*	*Reduced pain severity*

Please feel free to list any additional goals for treatment:

Please list all medications you are currently taking:

MEDICATION ALLERGIES:

PREFERRED PHARMACY:

PHARMACY ADDRESS: