Name____ SSN __________________

Complaint: Headaches

When did the pain begin? _________________

Episodes:

1-4 Minuets	5-15 Minutes	!5-30 Minuets	30-60 Minutes
More than an hour			

Severity:
On a scale of 1 to 10 (0 being no pain and 10 being the worst pain imaginable), how would you rate your pain now? _____________

Status:

Improved	No Change	Worse	Resolved

Frequency:

Intermittent	Constant	Daily	Weekly
Monthly			

Location:

Please refer to page 3 for a diagram

Does the Pain Travel Anywhere?

Front of Head	Back of Head	Neck	Shoulders
Upper Back	Ears	Sinuses	

Quality:

Blinding	Debilitating	Dull	Lancinating
Pressure	Sharp	Squeezing	Stabbing
Superficial	Throbbing	Worse Ever	Other___________

Timing (some will not all that apply)

Daytime	Menstrual Period	Upon awakening	Weekday

Name____ SSN __________________

Weekends Other ______________________________________

Aggravated By:

Allergies	Anxiety	Bright Lights	Caffeine
Exercise	Head Position	Foods	Noise
Stress	Nothing	*Valsalva	Weather

Relieved By:

Analgesics	Bath	Darkness	decongestants
Distraction	Heat	Ice	Massage
OTC Medications	Positions	Prescription Drugs	Relaxation
Sleep	Stretching		

Context:

Head Trauma, explain____

____

Trauma: MVA
Year_________ Air Bag Deployment YES NO Seat Belt

Specify____

Associated Symptoms/ Pertinent negatives

Blurred Vision	Clear Sinus Discharge	Dizziness
Family Hx of Migraine	Fever	Head Trauma
Loss of sight on the left eye	Loss of sight on right eye	Memory Loss
Nausea	Performance Changes	Stiff Neck
Vertigo	Vomiting	Other_______________

Name____ SSN __________________

*** Valsalva-** The Valsalva maneuver is performed by attempting to forcibly exhale while keeping the mouth and nose closed. It is used as a diagnostic tool to evaluate the condition of the heart and is sometimes done as a treatment to correct abnormal heart rhythms or relieve chest pain.

Sleep Limitations:

Falling asleep Staying asleep Getting back to sleep

Not able to sleep on affected side Able to sleep on affected side

Awakening too early Waking # time per night ________

Please list all of your allergies. (None)

TYPE OF PAIN YOU ARE CURRENTLY EXPERIENCING...

Place appropriate symbol or letter on the diagram.

Ache = AAAAA
Numbness = NNNNN
Pins and Needles = OOOOO
Burning = XXXXX
Stabbing = / / / / /