Headache Pain Screen: Are you experiencing pain now?	YES	NO
Is pain part of the reason why you are here?	YES	NO

Headache History:

How long ago did your headaches start (What age)? ___________________________

Location (Circle): Front of head / Top of head / Back of Head/ Neck

Right side only / Left side only/ Both sides

Pain characteristic (Circle): throbbing / dull / pressure / sharp / burning / other

Do you have any of the following symptoms during your headaches?

Nausea / Vomiting	Numbness / Tingling
Flashing lights, zig zags, spots	Hot, flush, watery eyes, runny nose
Blurry/ double vision	Dizziness (spinning sensation)
Light sensitivity	Lightheadedness (feel like laying down)
Noise sensitivity	Difficulty talking or walking
Ringing or noise in the ears	Loss of consciousness

Severity at Worst (Circle):

Length of Headache (Circle): seconds / 30 minutes / 1 hour / several hours / all day

Frequency of Headaches: Number of headache days ______ (per week / month)

Most common time of day (Circle): Morning / Afternoon / Evening / Anytime

Number of days of school missed due to Headaches this school year: __________

Headache triggers (Circle): Changes in weather / Stress, Lack of sleep / Caffeine Use / Chinese food (MSG) / Processed meats / Chocolate / Aged Meats /Aged Cheeses / Certain Smells / Menstrual Cycle / Exercise / Noise / Light

What makes your headaches worse? ____________________________________

What makes it better? ____

How often do headaches wake you up from sleep? Never / ________ times

Current Medications for headaches (Circle):

Ibuprofen / Tylenol / Excedrin / Naproxen / Sumatriptan / Rizatriptan

Other medications or treatments tried: ___________________________

How often do you take pain medication? ___________ (per week / month)

Previous Medications / Treatment tried for headaches: ____________________

Lifestyle Habits:

Bed time: ______________PM Wake time: _______________AM

Sleep problems (Circle):

Falling asleep / staying asleep / snoring / daytime sleepiness

Do you skip meals? Breakfast / Lunch / Dinner / Picky Eater / No

Do you eat green vegetables and/or take multivitamins daily? No / Yes

How many cups/bottles of water do you drink? ____________ (per day)

Do you drink Caffeine – Coffee, Tea, Soda (Coke, Dr. Pepper, etc)?

No / Yes, how many? _________________ (per day/ week)

Do you routinely exercise or participate in sports? No / Yes

Have you ever had a concussion/ head injury? No / Yes When?____________

Vision Checked recently? No / Yes; approximate date: __________________

Any stressors at school / family / personal? __________________

Other concerns today? ____

Do you have a family history of the following and who has it?

Migraine Headaches	Brain tumor
Other Headaches types	Seizures / Epilepsy
Brain aneurysm	Strokes before age 60 years

Have you had any previous testing / evaluations?

CT Head	MRI Brain	Neurologist	Ophthalmologist	Other:

Patient Information Sticker