

HEADACHE HISTORY AND PROFILE

Name: _____ Date of Birth _____ Date _____

How often does the headache occur? ____ x / Day ____ x / Week ____ x / Month ____ x / Year ____ Constant

How old were you when any headaches started? _____

How long does the headache usually last? _____ Minutes _____ Hours _____ Days _____ Constant

Is the headache getting worse better fluctuating no change

Do your headaches interfere with or prevent normal activities - work, etc? No Yes

How long ago did the current headaches start? _____ Weeks _____ Months _____ Years

Describe the degree of pain (check one) 1 (slight) 2 3 4 5 6 7 8 9 10 (worse)

How would you describe the pain? Throbbing/ pulsating Does the headache awaken you from sleep?

Pressing/ squeezing Stabbing Dull/ nagging Other Yes No

On what part of the head do the headaches start?

R Side Both sides Forehead Back Face Behind/ around eyes

L Side Either side Temples On top Neck Other _____

After the headache starts: Does it usually Stay in one place Move around? Please explain:

Are any of the following associated with the headache? Please mark Before During After the headache occurs.

B D A

- Spots before eyes
- Blindness R L
- Blurring R L
- Double vision
- Can see only half of objects
- Eyelid droop R L
- Tearing R L
- Eye redness R L
- Eyes puffy R L
- Light sensitivity
- Noise sensitivity
- Odors sensitivity
- Nose blocked/ discharge R L

- Difficulty talking (finding words)
- Difficulty understanding
- Numbness around lips
- Slurred speech
- Fainting (feel like or have fainted)
- Dizzy (lightheaded/ unsteady/ spinning)

B D A

- Nausea
- Vomiting
- Loss of appetite
- Hunger
- Cramps
- Diarrhea

Hands and/or Feet:

- Cold
- Pale
- Sweaty
- Mottled

Neck:

- Stiff
- Tender

B D A

- Face R L
- Arms R L
- Arm & Leg R L
- Legs R L

B D A

- Difficulty concentrating
- Depression
- Fatigue
- Anxiety
- Irritability

Face - Scalp:

- Pale
- Redness
- Sweating
- Puffy
- Tender
- Decreased jaw opening
- Pain on chewing

W N B

- Weakness (**W**)
- Numbness (**N**)
- Both (**B**)

Indicate if any of the following factors have brought on (triggered) your headache:

- Sleep: too much / too little
- Emotional stress during after

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- Depression / anxiety
- Physical activity
- Erect position
- Bending over
- Straining / coughing
- Sexual activity
- Change in weather
- Seasons

- Chocolate
- Citrus fruits
- Cheeses
- Other Foods

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- Missed meal
 - Alcohol
 - MSG

- Menstrual periods
- Pregnancy
- Menopause
- Contraceptions
- Medications

Do any blood relatives have severe headaches? No Yes

If yes, who and diagnosis?

Which of the following makes the headache better?

- Rest
- Activity
- Darkness
- Quiet

Social History:

Cigarettes / day years

Are you or have you been Depressed Anxious

Previous professional treatment of headache? No Yes

If yes, who and when?

Previous x-ray or other investigations of headache? No Yes

If yes, describe:

Previous medications for headache? No Yes

If yes, name/ dosage:

Additional Notes: