AMENT HEADACHE CENTER

HEADACHE DESCRIPTION FORM

Instructions:

- Answer each question the best you can.
- Mark all answers that apply to this headache type
- If the answer varies, give the answer that is most typical of your headaches.
- If you can't answer, or it doesn't apply, you may leave the question blank.
- ***If you have more than one type of headache,*** *then please fill out a separate Headache Description Form for each type.*

When did this headache pattern start? _____

Was there some event in your life that may have started this headache pattern? ☐Yes ☐No

If so, please explain: _____

_____

_____

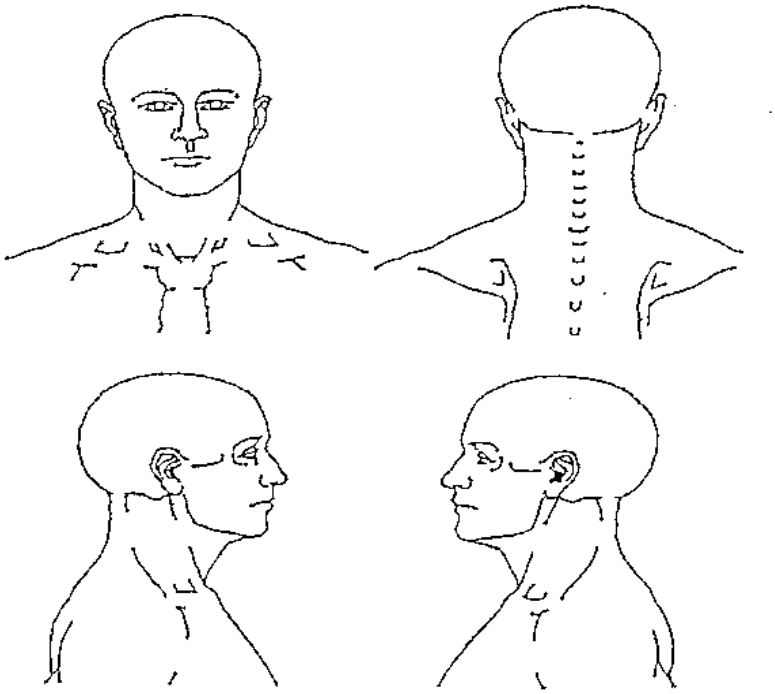
Do you get a warning sign before you get a headache?

☐Visual change ☐Fatigue ☐Ringing in the ears

☐Off balance ☐Sensory change ☐Localized weakness / numbness

☐Other: _____

Where does it start & where does it spread to? (please mark on the drawings)



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How painful does it typically get?

Pain Scale:
1 = mild/moderate pain, but can function normally
2 = moderate/severe pain, but still can do some things
3 = severe pain, have to stop/cannot function
4 = worst pain of your life/true agony

|_____|
1 2 3 4

How fast does it build, from no/minimal pain to its maximum pain level?

☐Seconds ☐Minutes ☐1hr ☐2-5hrs ☐6-12hrs
☐1day ☐2days ☐>2days ☐Varies/No Pattern

How long does it typically last, **without treatment?**

☐Seconds ☐Minutes ☐1hr ☐2-5hrs ☐6-12hrs
☐1day ☐2days ☐>2days ☐I don't know. I always treat it with something.

How long does it typically last, **with treatment?**

☐Seconds ☐Minutes ☐1hr ☐2-5hrs ☐6-12hrs
☐1day ☐2days ☐>2days

How do you treat your headache now (medications, other measures)?

_____
_____
_____

What does it feel like; how would you describe the pain?

☐Throbbing/pulsing ☐sharp/stabbing ☐burning/tingling
☐Pressure/squeezing ☐dull/nagging ☐jab/jolt
☐Other:_____

What time does your headache usually start?

|_____|
Midnight 6AM Noon 6PM Midnight
☐Unpredictable

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Associated Symptoms

During a headache, do you have any of these symptoms? (check ALL that apply)

☐Light sensitivity ☐Sound Sensitivity ☐Sensitivity to smells ☐Nausea
☐Vomiting

☐Blurred vision ☐Double vision ☐Zigzag lines ☐Tunnel vision
☐Blind spots ☐Bright spots ☐Colored spots

☐Pupil size change ☐Eyelid droop: Left/Right ☐Red/injected eye ☐Tearing
☐A feeling like there's something in the eye ☐Stuffy nose

☐Tingling/numbness; where?_____ ☐Weakness; where: _____
☐Jabs/jolts of pain ☐Vertigo/light headed/room spinning/sensation of movement
☐Falling ☐Ringing in the ears ☐Whooshing sound in the ears
☐Poor concentration ☐Confusion ☐Slurred speech
☐Passing out/Loss of consciousness ☐Seizures

☐Restlessness/can't hold still ☐Do you pace/rock?
☐Do you hit your head?

Headache triggers/Precipitating factors

Which of these things will set off this type of headache? (check ALL that apply)

☐Bright lights ☐Sun ☐Stress ☐Letdown
☐Weather changes ☐Change in sleep patterns ☐Allergies/Sinus
☐Hormonal changes: Menstrual period/ovulation/pregnancy/post-partum/contraceptives
☐Travel/time zone changes ☐Travel to Altitude ☐Fasting
☐Alcohol ☐Foods:_____ ☐Chewing/talking
☐Exercise / exertion ☐Position changes ☐Cough/strain ☐Orgasm
☐Flashing lights ☐Other:_____

NOTES (Other things you wish us to know):

_____
_____
_____
_____
_____
_____

Thank you!

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