AMENT HEADACHE CENTER

HEADACHE HISTORY FORM

Instructions:

- Answer each question the best you can.
- 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.

During the last 6 months, how many days of the month do you have a headache, *on average*? (circle a number)

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

During an average month, what percentage of your headaches are:
Severe: _____%
Moderate: _____%
Mild: _____%
Total: 100%

Are they increasing in:
Frequency? ☐Yes ☐No
Duration? ☐Yes ☐No
Severity? ☐Yes ☐No

How old were you when you first started having headaches? _____

Since you started getting headaches:
What is the longest you have had a continuous headache? _____
What is your longest headache-free period? _____

Was there a specific timeframe when your headache pattern changed? ☐Yes ☐No
If so, please explain: _____

Are you ever completely free of all pain in the head and the neck? ☐Yes ☐No

In the last **6 months** (if none, record as 0):
Days missed from Work due to headache _____
Days missed from Family/Social events due to headache _____
Trips to the Emergency Department due to headache _____

Have you ever been admitted to the Hospital for treatment of your headaches (longer than an ER visit?)
☐Yes ☐No _____

Have you ever sought treatment for your headaches at a National Center (e.g.: Mayo Clinic, Diamond Clinic, MHNI, Cleveland Clinic, Jefferson Clinic, etc) ☐Yes ☐No _____

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Have you ever had (in your life):

☐Whiplash ☐Concussion

☐Been in a motor vehicle accident ☐Had other trauma or surgery to your head or neck

Dental:

☐Frequent cavities/poor dentition ☐Frequent/significant dental work

☐Grind teeth ☐Trouble with the jaw: R / L / Both sides

Headache relief measures:

Please list all medications that you have taken over the last 6 months for headache relief. Include all over the counter medications or supplements, such as aspirin, ibuprofen, Tylenol, Excedrin, etc.

Effectiveness scale (-1 0 1 2):

-1 = made it worse **0** = no effect **1** = somewhat helpful **2** = very helpful

Rx	Frequency/week	Effectiveness
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2
		☐-1 ☐0 ☐1 ☐2

Other relief measures?	Effectiveness
Ice	☐-1 ☐0 ☐1 ☐2
Heat	☐-1 ☐0 ☐1 ☐2
	☐-1 ☐0 ☐1 ☐2
	☐-1 ☐0 ☐1 ☐2
	☐-1 ☐0 ☐1 ☐2

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Additional treatments you have tried	Effectiveness
Chiropractic	☐-1 ☐0 ☐1 ☐2
Acupuncture	☐-1 ☐0 ☐1 ☐2
Biofeedback	☐-1 ☐0 ☐1 ☐2
Massage	☐-1 ☐0 ☐1 ☐2
Dry needling	☐-1 ☐0 ☐1 ☐2
Trigger point injections	☐-1 ☐0 ☐1 ☐2
Occipital nerve blocks	☐-1 ☐0 ☐1 ☐2
Botox	☐-1 ☐0 ☐1 ☐2
Pain blocks (facet injections, etc.)	☐-1 ☐0 ☐1 ☐2
Implanted stimulators	☐-1 ☐0 ☐1 ☐2
Dental Surgery	☐-1 ☐0 ☐1 ☐2
Sinus Surgery	☐-1 ☐0 ☐1 ☐2
TMJ Surgery	☐-1 ☐0 ☐1 ☐2
C-spine/Neck Surgery	☐-1 ☐0 ☐1 ☐2
Other:	☐-1 ☐0 ☐1 ☐2
Other:	☐-1 ☐0 ☐1 ☐2

Prior Testing

Below is a list of common tests/procedures that people often have. Please mark ALL that apply.

Testing	Year/Findings (normal/abnormal)
MRI Brain	
MRI Neck	
MR Angiogram	
MR Venogram	
CT Brain	
CT Sinuses	
CT Neck	
CT Angiogram	
CT Venogram	
Cervical Spine X-Rays	
Spinal Tap	
EEG (brain wave test)	
Sleep study (not in the home)	
Conventional Angiogram	
Carotid Artery Ultrasound (neck)	
Echocardiogram (heart)	

Testing	Year/Findings (normal/abnormal)
Tilt Table Test	
TMJ testing	
Electroconvulsive therapy (ECT)	
Neuropsychological Testing	

NOTES (Other things you wish us to know):

_____
_____
_____
_____
_____
_____

Thank you!

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