Neurosurgery Associates
Headache Intake Questionnaire

393 E Town Street, Suite 110
Columbus, OH 43215

First Name:_____ **Last Name**:_____

Date of Birth:_____ **Age:** _____

Referring Doctor:_____

Pharmacy: _____

Primary Insurance: _____

Place of Birth: _____

Marital Status:

Single Married Common Law Divorce Widowed Separated

Age of Children (if applicable): _____

How would you rate your health in general?

□ Excellent □ Good □ Average □ Poor

Current Health Problems:_____

Past Medical History:

_____

Past Surgical History and Injuries:

_____

Current Medication and Supplements:

_____

Family History (Headaches, Brain tumors, Chiari malformation, etc):

_____

Work History:

Highest Level of Education: _____

Current Occupation: _____

Currently Working: Yes No Disabled Retired

Self-Employed? Yes No

Hours per Day: ____ Hours per Week: _____

Length of Time with Current Employer: _____

Stress Level: Low Medium High Extreme

Lifestyle Health Behaviors:

Sleep Questions:

How many hours of sleep do you get each night? _____

Do you have problems falling asleep? Yes No

Do you have problems staying asleep? Yes No

Eating Behavior:

Do you eat breakfast each morning? Yes No

Do you eat lunch each day? Yes No

How much caffeine do you consume daily?

Cups of Coffee -___ Tea -___ Soda -___

Smoking:

Do you currently smoke? Yes No

If yes, how much do you smoke? _____

Are you a former smoker? Yes No

When did you quit? _____

Drugs & Alcohol:

Have you used illicit drugs? Yes No

If so, which drugs? _____

Have you had problems with illicit drugs? Yes No

If so, which ones? _____

How much alcohol do you drink on average per day? _____

Per week? _____ or Per month? _____

Have you ever had a problem with alcohol? Yes No

Stress:

Stress level at work:

□ Mild □ Moderate □ High □ Very High

Do you manage stress well? Yes No

How or what do you use to manage stress? Check all that apply:

□ Exercise □ Relaxation techniques □ Hobbies □ Prayer/Spiritual

□ Family Relationships □ Social Relationships

HEADACHE SPECIFIC HISTORY

Onset headaches:

Did you suffer from headaches when you were younger?

Child teenager 20s to 40s 50s to 60s

When were your headaches at their worst?

When did your current headache problem begin?

_____ Months ____ Years ago

Precipitating Events - Was there a precipitating event or trigger for your current headache problem?

□ Not known □ Specific stress □ Injury □ Motor vehicle accident

□ Illness □ Menarche □ Birth control pill □ Pregnancy

□ Hormone replacement □ Other: _____

Headache Characteristics:

Frequency of headaches - On average how often do you have headaches?

They occur _____ times each day week or month

Are they increasing in frequency? Yes No

Are they more frequent on weekdays or weekends? _____

Worst in Spring, Summer, Fall, or Winter or all the same? _____

Onset (start) of each headache:_____

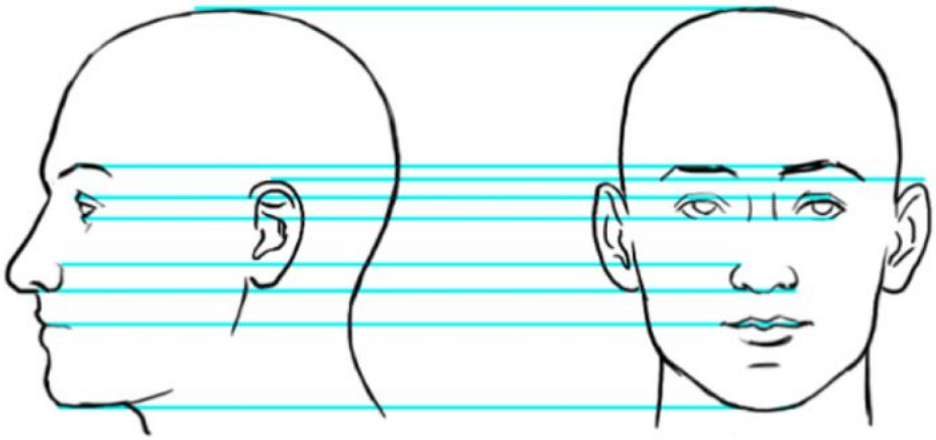
Duration of the headache:_____

Intensity of the headache (0-10): _____

Location of the headache (also use diagram): _____

Where on the head do the headaches begin, and does the pain move:_____

What Pain type: Sharp, pressure, etc. _____



Headache triggers (check all that apply)

□ Food □ Menstruation □ Caffeine □ Skipping meals □ Fatigue

□ Stress □ Exercise □ Sexual activity □ Loud sounds

□ Bright lights □ Alcohol □ Sleep deprivation

□ Bending over □straining/coughing □ Other: _____

Premonitory Symptoms - Do you experience any of the following **before** your headache begins? Check all that apply:

□ Mood changes □ Appetite change □ Neck pain □ Food cravings

□ Fatigue □ None □ Other:_____

Aura Symptoms - Do you ever experience any of these warnings symptoms ***before*** your headache begins?

□ Bright lights □ Flashing lights □ Zigzag lines □ Numbness

□ Dizziness □ Vertigo □ Loss of vision □ Blurry vision □ Paralysis

□ Nausea □ None

Associated Symptoms - Do you experience any of these symptoms ***during*** your headache?

□ Nausea □ Vomiting □ Bright lights bother you □ Loud sounds bother you

□Droopy face □motor weakness □ Strong smells bother you

□ Dizziness □ Lightheadedness □ Mood changes

□ Vertigo □ Numbness □ Increased sensitivity of scalp or ears

□ Eye tears □ Difficulty concentrating □ Running or stuffy nose

Alleviating factors - During a headache, what makes you feel more comfortable? Check all that apply:

□ Lying down □ Sleeping □ Keeping physically active

□ Massaging your head □ Cold pack on neck or head

□ Being in a dark quiet room □ Pacing back and forth

□ Tying something around your head □ Hot packs on head or neck

Doctor visits for headaches - how many times would you estimate that you have visited the following because of your headaches in the **past year**?

Family physician _____

Walk-in clinic _____

Emergency department _____

How many days of **work or school** in the past year have you missed because of your headaches? _____

Headache related Investigations (previous testing):

Have you had any of the following tests done to investigate your headaches? If so, please indicate the approximate date:

CT Head _____
MRI Head _____
MRI Neck _____
EEG (Brain waves) _____
Sinus X-Ray _____
Neck X-ray _____
Sleep Study _____
Other _____

Previous consultations:

Have you seen any of the following about your headaches? If so, please give the approximate date:

Neurologist _____
ENT _____
Dentist _____
Psychiatrist _____
Pain clinic _____
Eye doctor _____
Internal medicine _____
Allergy specialist _____
Other fields _____

Headache specific treatment from Non-Traditional fields - *have you seen any of the following about your headaches?*

□ Chiropractor
□ Massage therapist
□ Physical therapist
□ Psychologist
□ Herbalist
□ Acupuncturist
□ Nutritionist
□ Neuropath

Headache Related Purchases - have you purchased any of the following to try to treat your headaches?

□ Hot packs □ Cold packs □ Eye masks □ Aromatherapy
□ Neuropathic medicines □ Headache self-help book □ Mouth guard
□ Herbal supplements □ Anti-inflammatory rubs □
Other_____

Headache Relief from Medication - *how long* does it take before you become pain free after taking your current headache medications?

□ Within 1 hour □ 1-2 hours □ Greater than 2 hours
□ Greater than 24 hours
□ I never become pain free after medicine use

Current headache <u>Treatment</u> medications - Please include all over the counter and prescription medications and pain relievers that you currently are using **to treat** your headaches. (Do not include preventative medications).
(**Examples** include: triptan, Maxalt, relpax, amerge, zomig, Imitrex, frova, etc.)

<u>Medication</u> **<u>Dose</u>** **<u>Side Effects</u>**

_____

_____

_____

_____

Current headache <u>Preventative</u> medications - Please include all prescription and herbal products that you are currently using to prevent your headaches?
(**Examples** include: Topomax, valproic acid, amitriptyline, topiramate, beta blockers, inderal, lopressor, propranolol, anti-depressants, etc.)

<u>Medication</u> **<u>Dose</u>** **<u>Side Effects</u>**

_____

_____

_____

_____

Previously tried headache Treatment medications - Please include all over the counter and prescription medications that you have previously used **to treat** (not prevent) your headaches but have stopped using:

Medication Dose Side Effects

_____

_____

_____

Previously tried Medications to prevent headache medications -

Medication Dose Side Effects

_____

_____

_____

Interventions:

Did you ever get trigger point injections for Headaches or neck pain? _____

Did you ever get botox injections for headaches or neck pain? _____

What you consider injections if medications don't work? Yes No

Headache Specific Quality of Life Questionnaire -

Please answer each of the following 12 questions by checking the **One** best answer.

1. In the past 4 weeks, how often have headaches interfered with how well you've **dealt with family, friends**, and others close to you?
   - □ None of the time □ Some of the time
   - □ Most of the time □ All of the time
2. In the past 4 weeks, how often have headaches interfered with your **leisure activities** such as reading or exercising?
   - □ None of the time □ Some of the time

□ Most of the time □ All of the time

3. In the past 4 weeks, how often have you had difficulty **performing work or daily activities** because of headache symptoms?
   □ None of the time □ Some of the time
   □ Most of the time □ All of the time
4. In the past 4 weeks, how often have headaches limited your **ability to concentrate** on work or daily activities?
   □ None of the time □ Some of the time
   □ Most of the time □ All of the time
5. In the past 4 weeks, how often have headaches left you **too tired** (not energetic) to do work or daily activities?
   □ None of the time □ Some of the time
   □ Most of the time □ All of the time
6. In the past 4 weeks, how often have you had to **cancel work** or daily activities because of your headaches?
   □ None of the time □ Some of the time
   □ Most of the time □ All of the time
7. In the past 4 weeks, how often did you need help in handling **routine tasks** such as everyday chores or shopping when you had a headache?
   □ None of the time □ Some of the time
   □ Most of the time □ All of the time
8. In the past 4 weeks, how often did you have to **stop working** or daily activities to deal with headache symptoms?
   □ None of the time □ Some of the time
   □ Most of the time □ All of the time
9. In the past 4 weeks, how often were you not able to go to **social activities** such as parties or dinners with friends because you had a headache?
   □ None of the time □ Some of the time
   □ Most of the time □ All of the time
10. In the past 4 weeks, how often have you felt fed-up or **frustrated** because of your headaches?
    □ None of the time □ Some of the time
    □ Most of the time □ All of the time

11. In the past 4 weeks, how often have you felt like you were a **burden on others** because of your headache?
    - □ None of the time
    - □ Some of the time
    - □ Most of the time
    - □ All of the time
12. In the past 4 weeks, how often have you been afraid of **letting others down** because of your headaches?
    - □ None of the time
    - □ Some of the time
    - □ Most of the time
    - □ All of the time

Headache Management So Far- Questionnaire

Please rate the following questions by selecting the single best answer.

1. Overall effectiveness of treatment you currently use when headache attacks occur
    - □ Satisfied
    - □ Neutral
    - □ Dissatisfied
    - □ Does not apply to me
2. Overall effectiveness of treatment you currently use to prevent headache attacks from occurring
    - □ Satisfied
    - □ Neutral
    - □ Dissatisfied
    - □ Does not apply to me
3. Overall effectiveness of your current treatment on the **frequency** of your headache symptoms?
    - □ Satisfied
    - □ Neutral
    - □ Dissatisfied
4. Overall effectiveness of your current treatment on the **severity** of your headache symptoms?
    - □ Satisfied
    - □ Neutral
    - □ Dissatisfied
5. Your ability to self-manage headache symptoms
    - □ Satisfied
    - □ Neutral
    - □ Dissatisfied
6. Your ability to avoid conditions that may cause headache symptoms to occur
    - □ Satisfied
    - □ Neutral
    - □ Dissatisfied
7. The amount of money you spend on headache symptom treatment
    - □ Satisfied
    - □ Neutral
    - □ Dissatisfied

HEADACHE DISABILITY QUESTIONNAIRE (MIDAS Score):

Please indicate the number of days over the **past 3 months** that your headaches affected the activities described in questions 1 to 5 below.

1. How many days in the last 3 months did you miss work or school because of your headaches? _____
2. How many days in the last 3 months was your productivity at work or school reduced by headaches? _____
3. How many days in the last 3 months did you not do housework because of your headaches? _____
4. How many days in the last 3 months was your housework productivity reduced by 50% or more because of your headaches? _____
5. How many days in the last 3 months did you miss family, social or leisure activities because of your headaches? _____

A. How many days in the last 3 months did you have a headache? _____

B. On a scale of 0 to 10 (with 0 = no pain and 10 = pain as bad as it can get), what was the **average** severity of your headaches over the last 3 months? _____

Migraine Disability Assessment Score (MIDAS) disability Score: _____
(add scores from questions 1-5)

0 to 5 - MIDAS Grade I, Little or no disability

6 to 10 - MIDAS Grade II, Mild disability

11 to 20 - MIDAS Grade III, Moderate disability

21or over MIDAS Grade IV, Severe disability

Headache-Related Nutrition Questionnaire

1. Are you aware of any specific food triggers that can cause your headaches? Please list:

_____

2. If you are aware of food triggers, how did you become aware of your triggers? Please check all that apply, and provide detail if necessary:

□ Observation/instinct _____

□ Trial and error _____

□ By completing food/symptom diaries

_____

□ Suggestion from MD, dietician, naturopath

_____

□ Other (provide details) _____

3. Have you made any changes to your eating behaviors to help control your headaches? Strictly avoid specific trigger foods (list foods):

_____ Try to avoid certain trigger foods, but tend to be inconsistent (list):

_____

_____ Reduced my caffeine intake from _____ to _____

Changed meal frequency (provide details; how consistently?)

_____ Added breakfast: (yes/no; how frequent?)

_____ Improved my hydration (how much more fluid, what types?): _____

4. Please describe your **Weight**:

□ My weight has been fairly stable (within 10 lbs) in my adult life

□ My weight has increased over the years

□ My weight has gradually declined over the years

□ My weight tends to fluctuate up and down

5. **Do you Diet**, follow weight loss programs, or visit weight loss centres (e.g. Weight Watchers, Atkins diet, low carb,etc.)?

□ Never or almost never □ Yes, I've tried a few diet programs

□ Frequently. I usually try a few diets or programs each year

□ I'm constantly dieting

6. Do you currently, or have you ever tried **Supplements** (vitamins, minerals, herbs) to help control your headaches? Please list: supplement DOSE (if known) and length of time taken, and the IMPACT, if any.

Physical Activity Questionnaire

Do you engage in regular physical activity? □ Yes □ No

Do you have access to a fitness gym? □ Yes □ No

Do you have a personal trainer/fitness coach? □ Yes □ No

Equipment/Facilities Available:

Cardiovascular- □ Treadmill □ Stationary Bike □ Elliptical

Strength Training- □ Free Weights

Sports Equipment/Facilities- □ Tennis or Basketball courts

□ Golf Course/range □ Resistance Bands □ Pool □ Other

Patient signature: _____Date:_____

Provider signature: _____ Date: _____