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HEADACHE: ASSESSMENT **DATE:**

CLIENT: _____
DOB: _____

HEADACHE – SPECIFIC HISTORY

ORIGINAL ONSET

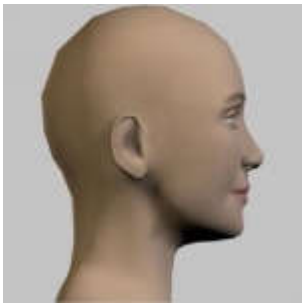
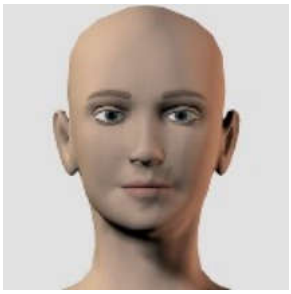
When did you originally start getting headaches? ☐ Child ☐ Teenager ☐ In my 20's–40's ☐ After 40
Was there an event originally? ☐ Stress ☐ Injury ☐ MVA ☐ Illness ☐Medication ☐ Pregnancy
☐ Other: _____
When did your current headache problem begin: _____
Was there an event or trigger for your current headache: _____

CURRENT COMPLAINT

On a scale of 0-10 (0 being no headache, 10 being the worst headache ever) please rate:
Your Current Headache: _____
Worst headache in the past 7 days: _____

How many headaches have you had in the past week? _____
Date of onset _____ How did your symptoms start _____
_____
Describe your symptoms:
_____
_____

5. Shade in the picture where your headaches occur most often:


HEADACHE – LIFE QUESTIONS

How would you rate your general health: ☐ Excellent ☐ Good ☐ Average ☐ Fair

SLEEP QUESTIONS:How many hours of sleep do you get each night? _____
Do you have trouble falling asleep? ☐ Yes ☐ No
Problems staying asleep? ☐ Yes ☐ No

EATING BEHAVIORS: Do you eat breakfast each morning? ☐Yes ☐No ☐ Sometimes
Do you eat lunch each day? ☐Yes ☐No ☐ Sometimes

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How much **caffeine** do you consume on average?
(#/day) ____Coffee ____Tea ____Soft drink/Cola/Pop/Coke

Are you aware of any **food triggers** that can cause your headaches? _____

Do you feel you consume **water** all throughout the day? (6-8 glasses per day) ☐Yes ☐ No

Describe your **weight**: ☐Fairly stable within 10 lbs
☐ My weight has increased over the years
☐ My weight has declined over the years
☐ My weight tends to fluctuate up and down

Are you a current **smoker**? ☐ Yes ☐ No If yes, how many per day? _____

Are you an ex-smoker? ☐ Yes ☐No If yes, when did you quit? _____

Stress Level at work: ☐ Mild ☐ Moderate ☐ High ☐ Very High

What other big things cause stress in your life now (health, relationships, financial): _____
_____

Do you manage stress well? ☐ Yes ☐No Describe: _____
How do you **manage Stress**? ☐ Exercise
☐ Relaxation Techniques
☐ Hobbies
☐ Spiritual Activities/Prayer
☐ Family Relationships
☐ Social Relationships

HEADACHE CHARACTERISTICS

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

They occur _____ times each ☐ Day ☐ Week ☐ Month
Are they increasing in frequency? ☐ Yes ☐ No
They are more frequent on: ☐ Weekdays ☐ Weekends
☐ Spring ☐ Summer ☐ Fall ☐ Winter

Onset of each headache:

Headaches typically begin: ☐ Gradually ☐ Suddenly ☐ Varies
They usually begin in the : ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Duration of headaches:

Headaches usually last (with medication) ____ ☐ Minutes ☐ Hours ☐ Days
Headaches usually last (without medication) ____ ☐ Minutes ☐ Hours ☐ Days

Intensity of headaches: *How bad can they get?*

With medication: ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating
Without medication: ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating
Headaches that prevent: ☐ School ☐ Work ☐ Household chores

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Location of Headaches - *Check any that apply.*

☐ Left side ☐ Right side ☐ May be either side ☐ Both sides ☐ Other _____
☐ Forehead ☐ Temple ☐ Behind eye(s) ☐ Back of head ☐ Neck

Pain Type - *What does the headache pain feel like?*

☐ Pressure ☐ Stabbing ☐ Throbbing ☐ Eye pain
☐ Tight band ☐ Burning ☐ Dull ache ☐ Other _____

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

☐ Bright lights / flashes of lights / multi-colored lights (circle applicable description)
☐ Zig-zag lines ☐ Partial loss of vision / blurry vision / blindness (circle applicable)
☐ Numbness/tingling ☐ Paralysis
☐ Increased sensitivity ☐ Upset stomach/nausea ☐ **No, I don't have these**

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

☐ Nausea /upset stomach ☐ Vomiting
☐ Bright lights/sun bothers you ☐ Loud sounds bother you
☐ Strong smells/odors bother you
☐ Dizziness / light-headedness / vertigo (circle applicable description)
☐ Numbness or tingling
☐ Increased sensitivity of Scalp / Hair / Ears
☐ Eye tears ☐ Runny or stuffy nose
☐ Difficulty concentrating ☐ Mood changes/irritability

Alleviating Factors - *During a headache, what makes you feel the most comfortable?*

☐ Lying down/sleeping ☐ Being in a dark quiet room
☐ Keeping physically active ☐ Pacing back-and-forth
☐ Massage your head ☐ Tying something around your head
☐ Cold pack on your head/neck ☐ Hot pack on your head/neck

HEADACHE- RELATED INVESTIGATIONS

Previous **Testing**- Have you had any of the following tests done to investigate your headaches? Date/Results

☐ CAT Scan _____
☐ MRI _____
☐ EEG _____
☐ Sinus X-Rays _____
☐ Neck X-Rays _____
☐ Allergy Testing _____
☐ Blood pressure monitoring _____
☐ Dental/TMJ Assessment _____
☐ Eye Examination _____

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- ☐ Kept a Food Diary _____
- ☐ Homeopathic Assessment _____
- ☐ Osteopathic Assessment _____
- ☐ Posture Assessment _____
- ☐ Other _____

Previous **Headache Treatment/Consultations** for your headache. Practitioner/Date

- ☐ Medications _____
- ☐ Neurologist _____
- ☐ Pain clinic _____
- ☐ Ear, nose and throat specialist _____
- ☐ Dentist/Dental Appliance (splint) _____
- ☐ Internal medicine _____
- ☐ Psychiatrist _____
- ☐ Acupressure _____
- ☐ Acupuncture _____
- ☐ Adequate Eye Correction _____
- ☐ ART _____
- ☐ Botox (Neck) _____
- ☐ Chiropractic _____
- ☐ Craniosacral _____
- ☐ Stress management _____
- ☐ Ergonomic Pillow _____
- ☐ Ice Application _____
- ☐ Massage therapy _____
- ☐ Heat Application _____
- ☐ Nerve Block _____
- ☐ Osteopath Treatment _____
- ☐ Physiotherapy _____
- ☐ Specific Food Avoidance _____
- ☐ Other _____