

# Headaches

Patient's Name: \_\_\_\_\_ Date \_\_\_\_\_

Where was the headache located when it first started?  
\_\_\_\_\_

Where is the headache located when it is fully developed?  
\_\_\_\_\_

### Describe the pain at onset of headache:

- |                                   |                                    |  |  |
|-----------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> Sore     | <input type="checkbox"/> Tightness | <input type="checkbox"/> Pressure      | <input type="checkbox"/> Cramping            |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Itching       | <input type="checkbox"/> Boring or drilling  |
| <input type="checkbox"/> Stinging | <input type="checkbox"/> Crushing  | <input type="checkbox"/> Shock-like    | <input type="checkbox"/> Can't be determined |
| <input type="checkbox"/> Aching   | <input type="checkbox"/> Stabbing  | <input type="checkbox"/> Raw sensation | <input type="checkbox"/> Other: _____        |

### Describe the pain when fully developed:

- |                                   |                                    |  |  |
|-----------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> Sore     | <input type="checkbox"/> Tightness | <input type="checkbox"/> Pressure      | <input type="checkbox"/> Cramping            |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Itching       | <input type="checkbox"/> Boring or drilling  |
| <input type="checkbox"/> Stinging | <input type="checkbox"/> Crushing  | <input type="checkbox"/> Shock-like    | <input type="checkbox"/> Can't be determined |
| <input type="checkbox"/> Aching   | <input type="checkbox"/> Stabbing  | <input type="checkbox"/> Raw sensation | <input type="checkbox"/> Other: _____        |

On a severity scale of 1-10 (1 being little pain at all and 10 being intolerable) my pain is a \_\_\_\_\_

### Measure the severity of the pain regarding how it affects your daily activities:

- Mild – I am aware of it when present but it doesn't interfere with daily activities
- Moderate – when present it interferes only with some daily activities
- Severe – when present it interferes with most, but not all, daily activities
- Very severe – when present I am unable to carry out any daily activities
- Other description of severity \_\_\_\_\_

Are you experiencing the pain now?  Yes  No

How long have you had the pain? \_\_\_\_\_

### Setting in which problem first occurred:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> During a sinus infection    | <input type="checkbox"/> After head or face trauma  | <input type="checkbox"/> While having sex          |
| <input type="checkbox"/> After a sinus infection     | <input type="checkbox"/> After starting a new job   | <input type="checkbox"/> While sleeping            |
| <input type="checkbox"/> After new dental appliances | <input type="checkbox"/> While at work              | <input type="checkbox"/> No apparent factors noted |
| <input type="checkbox"/> After dental extractions    | <input type="checkbox"/> While experiencing stress  | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> After dental repair work    | <input type="checkbox"/> While lifting or straining |  |

List any factors that aggravate the pain: \_\_\_\_\_

List any non-medical factors that relieve the pain: \_\_\_\_\_

### Please note any of these factors that go along with the pain:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Abnormal movements            | <input type="checkbox"/> Nightmares                          | <input type="checkbox"/> Sleep disturbance                  |
| <input type="checkbox"/> Bruixism (grinding the teeth) | <input type="checkbox"/> Problems with hearing               | <input type="checkbox"/> Stuffy, runny nose during headache |
| <input type="checkbox"/> Changes in vision             | <input type="checkbox"/> Problems with language              | <input type="checkbox"/> Dizziness                          |
| <input type="checkbox"/> Chronic nasal congestion      | <input type="checkbox"/> Problems with sense of smell        | <input type="checkbox"/> Vomiting                           |
| <input type="checkbox"/> Difficulty concentrating      | <input type="checkbox"/> Problems with sense of taste        | <input type="checkbox"/> Weakness                           |
| <input type="checkbox"/> Fever                         | <input type="checkbox"/> Recurrent sinusitis                 | <input type="checkbox"/> Other                              |
| <input type="checkbox"/> Malaise                       | <input type="checkbox"/> Red, watery eye on side of headache | <input type="checkbox"/> None                               |
| <input type="checkbox"/> Mental status changes         | <input type="checkbox"/> Seizures                            |   |
| <input type="checkbox"/> Nausea                        |  |   |

List any previous tests you have had: \_\_\_\_\_

List any previous treatments you have had: (home remedies, physical or occupational therapies, acupuncture or acupuncture therapies, massage therapy, chiropractic therapy, etc) and their effectiveness: \_\_\_\_\_

List any medications you have tried and their effectiveness: \_\_\_\_\_