403 Gilead Road, Suite B
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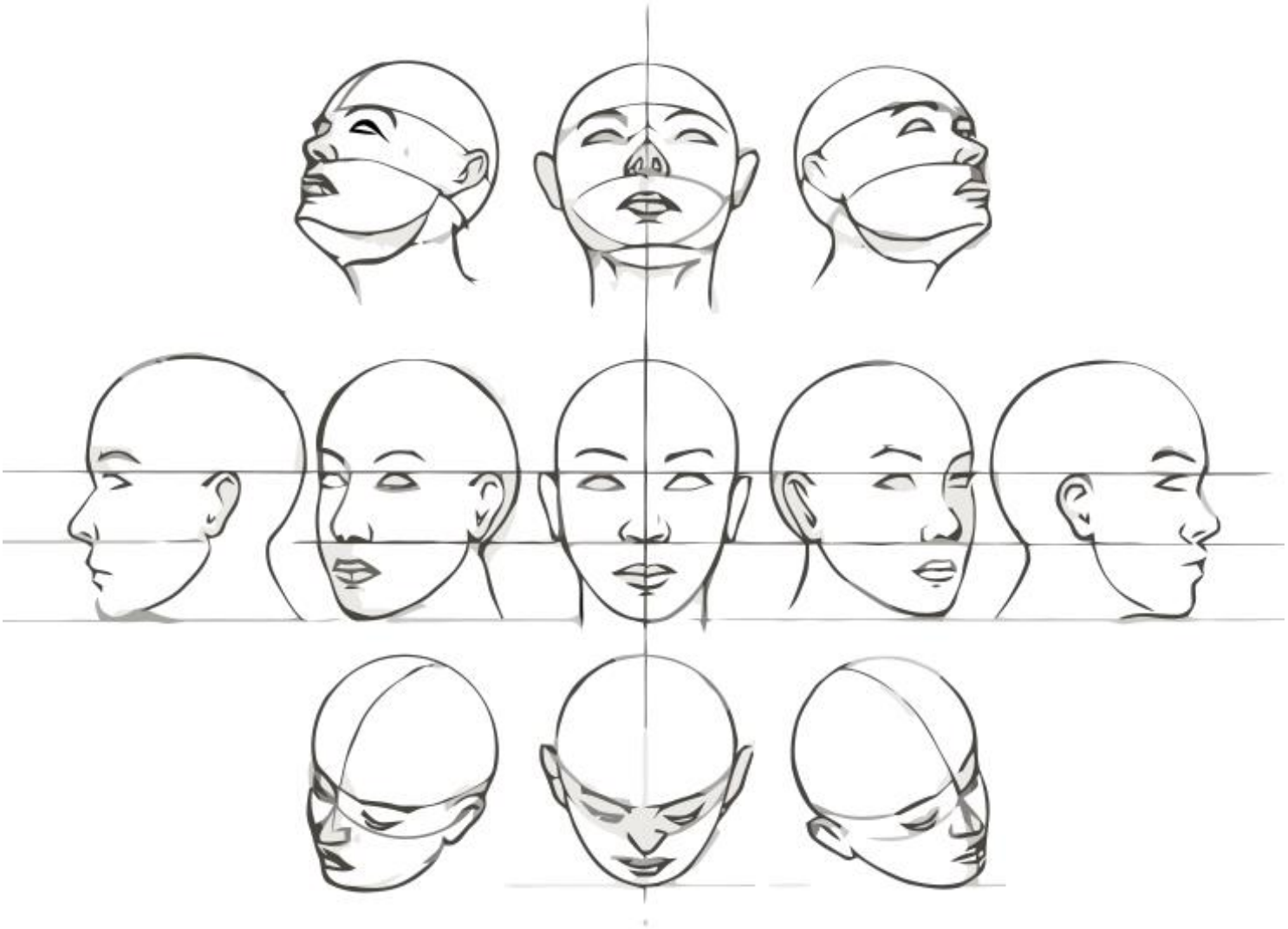
On the following diagram please shade the location of your headache or facial pain (please choose the **best** picture).

For multiple areas please **shade** ( ) the area that is most frequent, use **hash marks (////)** for second most frequent and **horizontal lines (----)** for the least most frequent.

RIGHT SIDE **LEFT SIDE**



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1) At what age or when did your symptoms begin? _____

2) Please circle **or** highlight the words that best describes you headache or facial pain:

Burning	Aching	Stabbing	Throbbing	Pulsing	Dull	Sharp	Icepick
Hot	Paralyzing	Scalding	Cold	Tingling	Stinging	Tender	Splitting
Pulling	Pinching	Crushing	Numb	Squeezing	Nagging	Nauseating	Dreadful
Troublesome	Electrical	Drilling	Shooting	Radiating	Sudden		

Other: _____

3) Please note the duration of a typical headache (choose most appropriate):

Seconds _____ Minutes _____ Hours_____ Days_____ Other_____

4) Please estimate the frequency of your headaches (choose most appropriate):

_____/Day _____/Month _____/Year

5) Are your headaches worse in the (please circle or highlight all that apply):

Morning Afternoon Evening Anytime

6) Please rank your pain:

Average Pain _____ Worst Pain _____ Best Day _____

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7) Please **circle** any other associated symptoms **with** your headache:

Light Sensitive	Sound Sensitive	Smell Sensitive	Nausea	Vomiting	Fatigue
Numbness	Weakness	Flashing Lights	Visual changes	Dizziness	Vertigo
Hearing Loss	Neck Pain	Back Pain	Fever	Chills	
Lack of Coordination	Speech Difficulties	Tremors	Tearing	Runny Nose	
Eye redness	Drooping of eyelid	Itching	Facial tenderness	Other: _____	

8) Please **circle** any of the following that seem to **trigger or worsen** your pain:

Coughing	Sneezing	Bending Over	Laying Down	Standing Up	Lights
Smells	Sounds	Foods	Stress	Menstruation	Allergies
Exercise	Movement	Medications	Lack of Sleep	Other: _____	

9) Please mark any of the **as needed** medications you have tried:

	++Tylenol (acetaminophen)		++ Advil (ibuprofen)		++Aleve (Naproxen)		++Goody powders		++Excedrin migraine
	Imitrex (sumatriptan)		Maxalt (rizatriptan)		Relpax (eletriptan)		Zomig (zolmitriptan)		Frova (frovatriptan)
	Amerge (naratriptan)		Treximet (sumatriptan/naproxen)		Zecuity (sumatriptan)		Sumavel (sumatriptan)		Cambia (diclofenac)
	*Diclofenac		*Fioricet (butalbital/APAP/Caffeine)		Midrin (APAP/isometh/dichlor)		Prodrin (APAP/caff/isometh)		Cafergot (ergotamine/caff)
	Ergotamine		Migranal (dihydroergotamine spray)		Axert (almotriptan)		Phenergan (Promethazine)		Zofran (Ondansetron)
	Reglan (Metoclopramide)		*Flexeril (Cyclobenzaprine)		*Zanaflex (tizanidine)		*Skelaxin (metaxalone)		*Ativan (lorazepem)
	*Valium (diazepam)		*Klonopin (clonazepam)		++Benadryl (Diphenhydramine)		*Vistaril (Hydroxyzine)		*Seroquel (quetiapine)
	*Codeine		*Hydrocodone		*Oxycodone				
Others:									

*denotes off-label use. ++Over the counter/Homeopathic

Which of these has been the most effective? _____

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10) Please mark any of the **preventative/daily** medications you have tried:

	Topamax (topiriamate)		Depakote (valproic acid)		*Neurontin (gabapentin)		*Lyrica (pregabalin)		*Keppra (levetiracitam)
	*Trokendi (topiramate)		*Qudexy (topiramate)		Inderal LA (propranolol)		*Corgard (nadolol)		*Zestril (lisinorpil)
	*Calen (verapamil)		*Cardizem (diltiazem)		*Procardia (nifedipine)		*Kapvay (clonidine)		*Intuniv (guanfacine)
	*Tenex (guanfacine)		*Peritol (cyproheptadine)		++Magnesium		++Feverfew		++Butterbur
	++B2 (riboflavin)		*Elavil (amitriptyline)		*Pamelor (nortriptyline)		*Prozac (fluoxetine)		*Celexa (citolapram)
	*Cymbalta (duloxetine)		*Effexor (venlafaxine)		Botox (Onabotulinumtoxin A)				
Other:									

*denotes off-label use. ++Over the counter/Homeopathic

Which of these has been the most effective? _____

11) Since having the pain have you done any of the following:

a. Been to the Emergency room for treatment. _____Yes _____No
   i. How often? _____/Mo _____/Year
b. Had any imaging of the brain? _____CT _____MRI?
c. Seen a specialist? (Circle all that apply)

Pain Management Chiropractor Acupuncture Neurologist

Headache Specialist Eye Doctor Dentist ENT Holistic

d. Are your headaches the result of a head injury? _____Yes _____No
e. Are there members of your family that suffer from headaches? _____Yes _____No
   i. Please List Relation: _____
f. Children only:
   i. How many days of school have you missed due to the headaches? _____
   ii. Do you play a competitive sport? _____Yes _____No