

PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

Please review and answer all parts of each question with our staff. Provide specific details/notes in the righthand column.

#	QUESTIONS																																													
1	<p>How often do you get severe headaches/migraines that make it difficult to function without treatment or medication?</p> <p>» <input type="checkbox"/> Occasionally</p> <p>» <input type="checkbox"/> More than twice a year</p> <p>» <input type="checkbox"/> More than once a month</p> <p>» <input type="checkbox"/> More than once a week</p>																																													
2	<p>How often do you get other milder headaches?</p> <p>» <input type="checkbox"/> Daily</p> <p>» <input type="checkbox"/> More than 3 per week</p> <p>» <input type="checkbox"/> More than 2 per month</p> <p>» <input type="checkbox"/> Other Please specify: _____</p>																																													
3	<p>Have your headaches changed in the last six months?</p> <p>» <input type="checkbox"/> About the same</p> <p>» <input type="checkbox"/> Slight worsening</p> <p>» <input type="checkbox"/> Same but more frequent</p> <p>» <input type="checkbox"/> A lot worse</p> <p>» <input type="checkbox"/> Got worse when _____</p>																																													
4	<p>What other doctors have you seen or tests have you had?</p> <p>_____</p> <p>_____</p> <p>_____</p>																																													
5	<p>What medications do you use for headache, migraine, or pain relief?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:40%;">MEDICATION (NAME OF MEDICATION OR SUBSTANCE)</th> <th style="width:30%;">WHAT DOSE?</th> <th style="width:30%;">HOW OFTEN?</th> </tr> </thead> <tbody> <tr> <td>Acetaminophen, Tylenol</td> <td></td> <td></td> </tr> <tr> <td>Ibuprofen, Advil, Motrin, Nuprin, etc..</td> <td></td> <td></td> </tr> <tr> <td>Naproxin, Aleve</td> <td></td> <td></td> </tr> <tr> <td>Rx pain medication ()</td> <td></td> <td></td> </tr> <tr> <td>Rx pain medication ()</td> <td></td> <td></td> </tr> <tr> <td>Rx muscle relaxant ()</td> <td></td> <td></td> </tr> <tr> <td>Rx anxiety medication ()</td> <td></td> <td></td> </tr> <tr> <td>Rx depression medication ()</td> <td></td> <td></td> </tr> <tr> <td>Rx migraine medication ()</td> <td></td> <td></td> </tr> <tr> <td>Medication for sleeping ()</td> <td></td> <td></td> </tr> <tr> <td>Caffeine intake ()</td> <td></td> <td></td> </tr> <tr> <td>Alcohol intake ()</td> <td></td> <td></td> </tr> <tr> <td>THC, Medical Marijuana ()</td> <td></td> <td></td> </tr> <tr> <td>Other: ()</td> <td></td> <td></td> </tr> </tbody> </table>	MEDICATION (NAME OF MEDICATION OR SUBSTANCE)	WHAT DOSE?	HOW OFTEN?	Acetaminophen, Tylenol			Ibuprofen, Advil, Motrin, Nuprin, etc..			Naproxin, Aleve			Rx pain medication ()			Rx pain medication ()			Rx muscle relaxant ()			Rx anxiety medication ()			Rx depression medication ()			Rx migraine medication ()			Medication for sleeping ()			Caffeine intake ()			Alcohol intake ()			THC, Medical Marijuana ()			Other: ()		
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I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION BEST DESCRIBES THE TREATMENTS AND MEDICATIONS I HAVE USED TO HELP ALLEVIATE MY HEADACHES/MIGRAINES/PAIN.

PATIENT SIGNATURE. _____