Appendix 23 - Migraine Assessment

Name _____ Date _____

Do you have more than one headache type? Yes No

If Yes, use one assessment for each type

1. When was the onset of the first headache? Headache started _____ years ago?
   I was younger than 20 20-29 30–49 50 and over

2. Precipitation Event (or trigger for your first event)
   None known Injury
   Menarche (First period) Pregnancy
   Other _____

3. Frequency
   They occur _____times each Day Week Month
   Are they increasing Yes No

   They are more frequent:
   Weekdays Weekends Vacations
   Spring Summer Fall Winter
   No relation

4. Onset of each headache: Gradual Sudden Varies
   Onset most frequent: Morning Afternoon Evening Night

5. Duration
   Lasts _____ Hours Days with medication
   _____ Hours Days without medication

6. Free of Headaches from _____ **to** _____ or Never free

7. Intensity:
   With medication: Mild Moderate Severe Incapacitating
   Without medication: Mild Moderate Severe Incapacitating

8. Headache's effect on your ability to function (i.e., Headache prevents normal activities such as work or school)
   Able to function normally
   Ability to function slightly decreased
   Ability to function severely decreased
   Totally bedridden

9. Starting Location:
   Left Side Right side Either side Both sides Behind eye(s)
   Neck/back of head Other _____

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10. Pain Type

Throbbing	Achy	Pressure	Stabbing	Shooting	Tight
Dull	Burning	Searing	Other _____		

11. Hormonal

Your headaches are affected by Your menstrual cycle Pregnancy

How? _____

12. Headaches can be brought on by:

Foods	Medications	Stress
Hunger	Sex/orgasm	Loud sounds
Alcohol	Physical exertion	Bright lights or sun
Fatigue	Menstruation	Odors
Lack of sleep	Coughing	Weather changes
Too much sleep	Chewing or talking	High altitude

Other _____

13. Warnings that headache is coming

Light flashes	Numbness	Upset stomach
Zigzag lines	Dizziness	Weakness
Blindness	Lightheadedness	
Other		

14. Associated symptoms

Nausea/vomiting	Diarrhea	Increased appetite
Sensitive to	Constipation	Decreased appetite
Light	Fatigue or weakness	Ringing in ears
Sounds	Insomnia	Anxiety, tension or irritability
Odors	Sore or stiff neck	Concentration/memory loss
One eye tear	Lightheaded/dizzy	Blurred or double vision
Both eyes tear	Numbness or tingling	Increased urination
Runny or stuffy nose	Changing in sexual interest	

Other _____

15. During a headache, you are more comfortable:

When lying down

In a dark, quiet room

Other _____

16. Previous testing (Please give date and results)

MRI _____	Cervical spine films _____
CAT scan _____	Sinus X-rays _____
EEG _____	Angiogram _____

Other _____

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17. Previous evaluations (Please give name, date and results)

Neurologist _____

Headache specialist _____

Internist _____

ENT specialist _____

Dental evaluation _____

Eye exam _____

18. Previous non-medical treatments and evaluations

Biofeedback/relaxation/self-hypnosis	Physical Therapy
Chiropractor	Nutritional counseling
Acupuncture/acupressure	Allergy testing

19. Are you currently taking medication(s) for headaches? Yes No
If yes, complete the Headache Medications form (below)

20. With the current medications(s), how quickly do you feel adequate relief of head pain and other symptoms?

Within 2 hours	In more than 2 hours
Relief is never adequate	Not currently taking medication

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