

Patient Name: _____
DOB: _____
DOS: _____



integrativepain
center of arizona

optimizing lives through integrative health care

Appendix A; Headache Data Collection Form

Name: _____ **Date:** _____
Date of Birth: _____ **Dr.** _____

General and Aura:

How old were you when you started to suffer from headaches?

<25 years +20 years +55 years

Do you have any warning symptoms (1-24 hours before pain onset):
elation/irritability, depression, drowsiness, hunger, or thirst?

Yes No

Do symptoms (such as visual disturbance, pins and needles, numbness, disturbed speech, confused thinking, dizziness, decreased hearing, noise in the ears, double vision, and/or incoordination) typically come a few minutes before a headache?

Yes No

The Headache

What kind of pain is it?

Pressure Tightening Throbbing Pulsating burning
 Stabbing Boring Bursting Other _____

Is the headache usually so severe as to stop you from performing your usual activities?

Yes No

Time characteristics

How many days of work or school have you missed *in the last month* because of headache?
(Please circle one)

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 >15

About how often do you have this type of headache each year?

<24/year >24/year >90/year Daily

How long does the headache last without medication or if it does not work?

1-4 hours 4-72 hours >72 hours

How long does it take to develop?

Instantaneously Within minutes 10-60 minutes Slowly

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Do the headaches occur in clusters lasting weeks?

Yes No

In the last 6 months, have you had a headache for at least 15 days a month?

Yes No

Does the headache usually start at the same time?

Night On waking Evening No

Are there days during the week on which you have a headache more often?

Yes No

For women only: Are there days in the month on which you have headaches more often?

Yes No

Has pregnancy affected your headaches?

Yes No

Spatial characteristics

Where in your head do you feel the pain?

Eye Forehead Temples Back of head All over/all round
 Not localized

Do you feel pain on one side or on both?

One Both

If on one side, is it always on the same side?

Yes No

If on both sides, does the pain start on one side?

Yes No

Precipitants

Do any factors precipitate a headache? (please check all that apply)

certain foods odors time of year changes in weather
 loss of sleep allergens flicker/glare menses
 sleep excess after stress jaw clenching relaxation
 hunger exercise neck movement smoking
 fatigue emotion sexual activity eyestrain
 stress

Chemicals such as:

caffeine ergot marijuana phenothiazines
 reserpine lead Vitamin A oral contraceptive pills
 SSRIs alcohol amphetamines Indomethacin
 levadopa clomiphene hydralazine histamine

Do you need to take pain-relieving medications?

Less than 2 days/week 3-5 days/week 6-7 days/week

Aggravants, relievants, and associated symptoms:

Do you find that you cannot keep still during a headache? YES NO

Do activities like walking up stairs make the headache worse? YES NO

Does bending or coughing worsen the headache? YES NO

Do you avoid even slight movements during a headache? YES NO

Does sleep (if possible during a headache) usually relieve it? YES NO

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During a headache:

- | | | |
|---|------------------------------|-----------------------------|
| Are you unusually sensitive to light and try to avoid it? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are you usually sensitive to noise and try to avoid it? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you feel nauseated? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you vomit? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you experience: irritability, hyperactivity, inability to think/concentrate, food cravings, mood variations, aversion to odors, or increased sense of smell? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Does your eye water on the painful side? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Does your nose plug up or run on the painful side? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do your face and forehead sweat on the painful side? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Does the pupil become smaller on the affected side? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Does your eyelid close on the painful side? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Are any other symptoms associated with the actual headache, such as:

- | | | |
|---|--|--|
| <input type="checkbox"/> loss of vision in one eye | <input type="checkbox"/> loss of vision to one side | <input type="checkbox"/> pallor |
| <input type="checkbox"/> double vision | <input type="checkbox"/> vertigo (spinning dizziness) | <input type="checkbox"/> seizures |
| <input type="checkbox"/> difficulty in saying words | <input type="checkbox"/> confused thinking | <input type="checkbox"/> faintness |
| <input type="checkbox"/> loss of memory | <input type="checkbox"/> weakness of one arm/leg | <input type="checkbox"/> incoordination |
| <input type="checkbox"/> face swelling | <input type="checkbox"/> numbness in one arm/leg | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> palpitations | <input type="checkbox"/> tingling (pins and needles in the face/limbs) | |

Other Factors

- Do any members of your family suffer from similar headaches?
 Yes No
- Did you get travel sickness or unexplained stomach pains as a child?
 Yes No
- Do you ever have ice-pick pains?
 Yes No
- Do you have other type(s) of headache besides the one you have described?
 Yes No
- (If yes, please describe on a different form)**

What medications have you ever taken for an acute headache?

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> ASA | <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Oxygen | <input type="checkbox"/> Fiorinal | <input type="checkbox"/> NSAIDs/Toradol |
| <input type="checkbox"/> DHE | <input type="checkbox"/> Codeine | <input type="checkbox"/> Xylocaine | <input type="checkbox"/> Imitrex injection | <input type="checkbox"/> Imitrex Nasal Spray |
| <input type="checkbox"/> Imitrex tablets | <input type="checkbox"/> Zomig tablets | <input type="checkbox"/> Zomig Nasal Spray | <input type="checkbox"/> Relpax | <input type="checkbox"/> Maxalt |
| <input type="checkbox"/> Frova | <input type="checkbox"/> Axert | <input type="checkbox"/> Amerge | <input type="checkbox"/> Migrainal | <input type="checkbox"/> Demerol |

What medications have you ever taken to prevent headaches?

- | | | | | |
|---------------------------------------|--|---|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Steroids | <input type="checkbox"/> Chlorpromazine | <input type="checkbox"/> Lithium | <input type="checkbox"/> Pizotifen | <input type="checkbox"/> Topamax |
| <input type="checkbox"/> Methysergide | <input type="checkbox"/> Depakote | <input type="checkbox"/> Cyproheptadine | <input type="checkbox"/> Tricyclics | <input type="checkbox"/> MAOIs |
| <input type="checkbox"/> Beta-blocker | <input type="checkbox"/> Ca ⁺ channel blocker | | | |

Past Health (please check any you have suffered)

- | | | | | |
|--------------------------------------|--|---|---|---|
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Neck injury/arthritis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Blood disorder |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinus disease | <input type="checkbox"/> Dental diseases | <input type="checkbox"/> Neck injury | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Jaw/joint problems | <input type="checkbox"/> Eye/ear problems | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma |