Headache & Facial Pain New Patient Intake Form

Part 1: General Medical Questionnaire

Name: **DOB:**

Handedness: Right Left Ambidextrous

Occupation:

Work status: Full time Part time Retired Homemaker Unemployed Disability

Living Arrangement: Alone With family With partner With roommate Care facility Other

Do you drive? No Yes

Do you have extended health benefits?

Preferred Pharmacy:

Height: **Weight:**

Medical History (List all medical conditions, diagnoses, and previous surgeries):

_____
_____
_____
_____
_____
_____

Medications (complete below or attach a list. Please include vitamins, herbals, and contraceptives)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies: No Yes: _____

Social Profile

Have you ever smoked? No Yes

If yes: How long? _____ How much? _____ If you quit, when? _____

Do you drink any alcohol? No Yes If yes, how much per week:

Any marijuana products? No Yes If yes, how much per week:

List any other recreational drugs used:

Family History

Neurologic diseases (brain, spine, nerve, muscle): _____

Autoimmune or rheumatologic diseases: _____

Headaches or migraine

Other: _____

Part 2: Headache Questionnaire

Please describe your symptoms below. If you have more than one type of headache or facial pain, multiple spaces have been provided:

Type 1:

- When did they start:
- Quality (what it feels like, where is the worst pain located):
- Severity (circle one): 0 (no pain) - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (worst pain possible)
- Duration (how long they last, both with and without taking medication):
- How they take to develop (e.g., seconds, minutes, hours):
- Frequency (days per month):

Type 2:

- When did they start:
- Quality (what it feels like, where is the pain maximal):
- Severity (circle one): 0 (no pain) - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (worst pain possible)
- Duration (how long they last, both with and without taking medication):
- How they take to develop (e.g., seconds, minutes, hours):

- Frequency (days per month):

Type 3:

- When did they start:
- Quality (what it feels like, where is the pain maximal):
- Severity (circle one): 0 (no pain) - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (worst pain possible)
- Duration (how long they last, both with and without taking medication):
- How they take to develop (e.g., seconds, minutes, hours):
- Frequency (days per month):

Associated features (check all that apply):

Mostly one-sided headache (Left/Right)
Pulsating, pounding, throbbing
Squeezing, headband, tension
Sharp, shooting, burning
Worsened by regular physical activity (exercise, housework)
Nausea or feeling put off from food
Vomiting
Sensitivity to sounds (TV, talking, music)
Sensitivity to bright lights
Sensitivity to smells (perfumes, cooking)
Need to rest in a quiet or dark place
Need to "sleep it off"
Dizziness or vertigo
Slow thinking & trouble concentrating
Mood alteration
Fatigue or malaise
Numbness or tingling:
_____
Weakness:
_____
Slurred speech
Trouble speaking or finding words
Visual aura (sparkling lights, zig zag lines, kaleidoscope vision changes)
Other warning or "aura" symptoms before a headache (describe)
_____
Vision loss or other vision changes:
_____

Hearing changes or ringing in the ears
Double vision
One sided eye tearing, runny nose, droopy or swollen eyelid, facial flushing/sweating, asymmetric pupils
Feeling restless, can't sit still
Headaches or facial pain attacks tend to come in clusters
Neck pain
Snoring or apnea (periods of not breathing) in sleep
Specific time of day when symptoms come on (nighttime, morning, etc.):
_____
Positional (headaches tend to come on when lying down or standing up)
Activity triggers:
- Strenuous exercise
- Coughing
- Valsalva (blowing nose, "popping" ears, lifting, or straining)
- Sexual activity

Severe headache starts in less than 60 seconds
Other:
_____
_____

Headache Frequency

Using the 0-1-2-3 scoring system, in a typical month, how many days do you experience the following headache days? Total should add up to 30

"0" (headache free days): __/30

"1" (mild, but can function): __/30

"2" (moderate, function is slowed or reduced): __/30

"3" (severe, cannot function): __/30

How many days in a month would you miss work, school, or an important personal activity? __/30

Headache Diary

If you keep a headache diary, please bring this into your first clinic assessment

If you do not keep a clinic diary, please start recording one in anticipation of your first clinic assessment.

Headache diaries can be found at:

- Smart phone app: https://migrainetracker.ca/
- Printable diary: https://headachesociety.ca/for-patients/

Headache Triggers (check all that apply):

Lack of sleep
Shift work
Menstrual cycles
Skipping meals
Not drinking enough fluid
Alcohol
Other: _____

Is there anything that makes your headaches better?

Have your seen another physician, specialist, or healthcare provider for your symptoms in the past?

_____

_____

Have you had any significant previous head or neck injury?

List any previous tests, imaging, or other investigations for your symptoms?

_____

_____

Have you tried any of the following for your symptoms?

Physiotherapist
Occupational Therapist
Massage therapist
Chiropractor
Acupuncturist
Naturopathic medicine provider
Meditation
Yoga
Other: _____

Lifestyle

- How many hours of sleep do you get per day? _____
- Do you drink enough water throughout the day? _____
- Do you often skip meals? _____
- How often and how much do you exercise? _____
- How many standard servings of caffeine do you consume per day (tea, coffee, cola, energy drinks)? _____
- Are you under a lot of stress? _____

Headache Preventative Medications

Please list any medications taken on a regular basis to prevent or reduce headaches (e.g., gabapentin, venlafaxine, topiramate, Botox, CGRP antibodies, beta blockers, etc.). Please provide the medication dose, benefit (if any), side effects (if any), reason for stopping, duration, and approx. dates taken wherever possible. *For example: Gabapentin 300 mg three times per day, taken for 6 months in 2020, stopped as no benefit and it made me drowsy.*

<u>Current:</u>

1. _____

2.
3.

Previous (no longer taking):

1.
2.
3.
4.
5.

Headache Abortive/Symptomatic Medications

Please list any medications you have taken to stop or reduce a headache and its symptoms once it has started (e.g., acetaminophen, ibuprofen, aspirin, naproxen, Imitrex, Maxalt, other triptans, DHE, Cambia, opioids, anti-nausea medications, etc.). Please provide the medication dose, benefit (if any), side effects (if any), reason for stopping, duration, and approx. dates taken wherever possible.

Current *(**Please list average number of days per month that you use each*):

1.
2.
3.

Previous (no longer taking):

1.
2.
3.
4.

Have you ever used any vitamins, minerals, or supplements for headaches? Please list below.

_____

Please list any procedural headache treatments such as nerve blocks, pain targeting injections, ganglion blocks, ablation procedures, etc.

_____

What are your goals for today's appointment?

1. _____
2. _____
3. _____

What are your most important questions for today's appointment?

4. _____
5. _____
6. _____

NAME: _____

DOB: _____ DATE: _____

HIT-6™ Headache Impact Test

HIT is a tool used to measure the impact headaches have on your ability to function on the job, at school, at home and in social situations. Your score shows you the effect that headaches have on normal daily life and your ability to function. HIT was developed by an international team of headache experts from neurology and primary care medicine in collaboration with the psychometricians who developed the SF-36® health assessment tool. This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please circle one answer for each question.

When you have headaches, how often is the pain severe?

never ▼ rarely ▼ sometimes ▼ very often ▼ always ▼

How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

never ▼ rarely ▼ sometimes ▼ very often ▼ always ▼

When you have a headache, how often do you wish you could lie down?

never ▼ rarely ▼ sometimes ▼ very often ▼ always ▼

In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

never ▼ rarely ▼ sometimes ▼ very often ▼ always ▼

In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

never ▼ rarely ▼ sometimes ▼ very often ▼ always ▼

In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

never ▼ rarely ▼ sometimes ▼ very often ▼ always ▼

☐ +	☐ +	☐ +	☐ +	☐
COLUMN 1 6 points each	COLUMN 2 8 points each	COLUMN 3 10 points each	COLUMN 4 11 points each	COLUMN 5 13 points each

To score, add points for answers in each column.

If your HIT-6 is 50 or higher:

You should share your results with your doctor. Headaches that stop you from enjoying the important things in life, like family, work, school or social activities could be migraine.

☐
TOTAL SCORE

Dr. Laura Baxter
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Neurologist

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Nanaimo, BC V9S 5H6
Ph (778) 787-1707 Fax (778) 787-1511

New Patient Assessment Questionnaire Date: _____

Name: **DOB:**

Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Occupation:

Work status: ☐ Full time ☐ Part time ☐ Retired ☐ Homemaker ☐ Unemployed ☐ Disability

Living Arrangement: ☐ Alone ☐ With family ☐ With roommate ☐ Care facility ☐ Other

Do you drive? ☐ No ☐ Yes

Do you have extended health benefits?

Preferred Pharmacy:

Height: **Weight:**

Medical History

(please list all medical conditions, diagnoses, and previous surgeries):

_____

_____

_____

_____

_____

_____

_____

Medications (complete below or attach a list)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies: ☐ No ☐ Yes *(list)* _____

Social Profile

Have you ever smoked? ☐ No ☐ Yes

If yes: How long? _____ How much? _____ If you quit, when? _____

Do you drink any alcohol? ☐ No ☐ Yes If yes, how much per week: _____

Please complete other side…

Any marijuana products? ☐ No ☐ Yes If yes, how much per week:_____

List any other recreational drugs used:

Family History

☐ Neurologic diseases (brain, spine, nerve, muscle)_____

☐ Autoimmune diseases_____

☐ Other_____

Description of Symptoms

What is the main issue/symptom for today's appointment?_____

_____

Provide a brief description of your issue/symptom _____

_____

_____

_____

_____

Duration of symptoms: _____

What treatments have you tried for this problem (medications, physio, message, alternative medicines, etc)?

_____

_____

What investigations (lab tests, imaging, etc) have been done? _____

_____

_____

Have you seen other specialists or health providers for this issue in the past? Who?

_____

_____

Top Questions for Today's Visit

1. _____

   _____

2. _____

   _____

3. _____

   _____

TEST TEST
15-Jun-1940

The Migraine Disability Assessment Test

The **MIDAS** (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS

Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

_____ 1. On how many days in the last 3 months did you miss work or school because of your headaches?

_____ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

_____ 3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

_____ 4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

_____ 5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

_____ Total (Questions 1-5)

What your Physician will need to know about your headache:

_____ A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)

_____ B. On a scale of 0 - 10, on average how painful were these headaches? (where 0=no pain at all, and 10= pain as bad as it can be.)

Scoring: After you have filled out this questionnaire, add the total number of days from questions 1-5 (ignore A and B).

MIDAS Grade	Definition	MIDAS Score
I	Little or No Disability	0-5
II	Mild Disability	6-10
III	Moderate Disability	11-20
IV	Severe Disability	21+

If Your MIDAS Score is 6 or more, please discuss this with your doctor.