

Headache Information

Patient Name: _____ DOB: _____

Please tell us more about your child's headaches and complete the following paperwork prior to your visit.

PLEASE COMPLETE THE FOLLOWING:										
1. I believe the primary cause of my child's headache is _____.										
2. My child is here because of: <input type="checkbox"/> School Concerns <input type="checkbox"/> Headache Concerns <input type="checkbox"/> Fainting <input type="checkbox"/> Other Concerns (describe below) _____.										
3. The headaches have been a problem for: <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years										
4. Did the headaches start with a specific illness or injury?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. My child has more than one type of headache. If yes, please describe: _____								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. Most of the headaches are similar.								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. My child complains of headaches: <input type="checkbox"/> Daily <input type="checkbox"/> _____ Times per Week <input type="checkbox"/> _____ Times per Month										
8. Is there a pattern to the headaches: similar days, hours, symptoms?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9. Does one part of the head hurt more? <input type="checkbox"/> Front <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Back <input type="checkbox"/> All Over										
10. Do you have neck or back pain?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
11. What symptoms are associated with the headache: (check yes or no below)										
Light Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sound Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Dots or Lines in Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Numbness of Arms or Legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tingling of Arms or Legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Other vision problems: _____										
Other symptoms: _____										
12. Headaches are more common: <input type="checkbox"/> Front <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Back <input type="checkbox"/> All Over										
13. Most of the pain lasts: <input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Most of the Day										
14. Does the headache arouse the child from sleep? <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Often										
15. Do the headaches interfere with your child's sleep?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
16. Do they keep your child from falling asleep?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
17. Do the headaches wake your child up in early morning? <input type="checkbox"/> Always <input type="checkbox"/> Occasionally <input type="checkbox"/> Never										
18. Have your child's headaches increased since they started in <input type="checkbox"/> Frequency <input type="checkbox"/> Severity <input type="checkbox"/> Both										
19. When did this worsen? _____ OR Have your child's headaches stayed about the same since they became a problem? _____										
20. Is there anything that seems to trigger the headache? <input type="checkbox"/> Food <input type="checkbox"/> Smells <input type="checkbox"/> Sound <input type="checkbox"/> Worry										

21. What makes the headache worse? (please check below)		
<input type="checkbox"/> Bending Over	<input type="checkbox"/> Sports	<input type="checkbox"/> Noise
<input type="checkbox"/> Standing Up	<input type="checkbox"/> Coughing	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Lights	<input type="checkbox"/> Hunger	<input type="checkbox"/> Stress
<input type="checkbox"/> Other: _____		
22. Does your child get motion sickness/car sickness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23. FOR FEMALES: Are headaches associated with menstrual cycle? If yes, please describe: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24. How many days of school has the child missed due to headaches this school year? _____		
25. When was the last day of school missed? _____		
26. How many days a month do headaches cause your child to stop activity and lie down? _____		
27. What other activities has your child missed due to headaches? _____		
28. My child has had tests for headaches. (include dates and results of all tests)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> CT Scan _____	<input type="checkbox"/> Dental Testing _____	
<input type="checkbox"/> MRI Scan _____	<input type="checkbox"/> Allergy Testing _____	
<input type="checkbox"/> Eye Exam _____	<input type="checkbox"/> Other Testing _____	
TREATMENT:		
1. What makes the headache better? _____		
2. Does the headache get better or go away with rest or sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. What medication treatment have you tried so far? (Include all over-the-counter, herbal and prescription medications, tablet size and dose tried for headache). _____ _____ _____		
4. Medications that seem to help: _____		
5. Is medication needed for nausea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. How often does your child use over the counter medications for headache? <input type="checkbox"/> Daily <input type="checkbox"/> _____ Times per Week <input type="checkbox"/> _____ Times per Month Which type? _____		
7. Have you tried? <input type="checkbox"/> Ice <input type="checkbox"/> Massage <input type="checkbox"/> Heat <input type="checkbox"/> Other: _____		
SLEEP:		
1. My child sleeps well most nights:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. My child has trouble: <input type="checkbox"/> Falling Asleep <input type="checkbox"/> _____ Staying Asleep <input type="checkbox"/> _____ Both		
3. My child usually falls asleep at _____ (time) during the week and awakens at _____ (time).		
4. Average hours of sleep per night during the week _____ on weekend _____.		
5. Was sleep a problem before the headaches started?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Has sleep been a problem since the headaches started?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. During sleep, does your child snore? If yes, is it: <input type="checkbox"/> Loud and often <input type="checkbox"/> Soft and occasional	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. During sleep does your child: <input type="checkbox"/> Grind Teeth <input type="checkbox"/> Walk <input type="checkbox"/> Talk		
9. Does your child sleep in parent's bed: <input type="checkbox"/> Almost Every night <input type="checkbox"/> Occasionally <input type="checkbox"/> Never		

HOME AND SCHOOL LIFE:

1. My child lives at home with (please check all that apply).

 Biological Mother Adoptive Parents Biological Father Siblings Grandmother Cousins Grandfather Other: _____

2. School is going well and without problems?

 Yes No3. There is some stress in my child's life at: Home School Friends

Please describe: _____

4. Any previous stress that has improved?

 Yes No

5. Is there any history of behavior or emotional problems?

If yes, please describe: _____

 Yes No

6. Does your child carry a heavy backpack for school?

 Yes No

7. My child spends _____ hours per day on the computer at home and _____ hours per day at school.

8. My child spends _____ hours per day using other electronics (TV, video games, cell phone).

9. My child spends _____ hours per day in some form of physical activity.

The usual physical activity is: _____

NUTRITION:

1. Is your child overweight?

 Yes No

2. My child eats breakfast _____ days per week.

Typical breakfast is: _____.

3. My child eats well-balanced meals and snacks throughout the day?

 Yes No

4. My child skips meals often.

 Yes No

5. What does your child typically drink during the day? _____

6. My child drinks _____ glasses of water per day.

7. My child drinks _____ glasses of caffeinated beverages per day. Type _____

OTHER MEDICAL CONCERNS/PAST MEDICAL HISTORY:

1. The pregnancy with this child was uncomplicated with full-term delivery.

If no, please describe: _____

 Yes No

2. My child has had normal language, gross motor and fine motor development.

If no, please describe: _____

 Yes No3. Has your child ever had: Seizures Meningitis Encephalitis Stroke Severe Head Injury

4. What other medical concerns/diagnosis does your child have? _____

5. Please list all other medications your child takes: _____

6. What other health care providers has your child seen in the last three years: _____

7. My child is allergic to the following medications: _____

8. Does the patient wear glasses or contacts? Last vision check: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Is there any history of behavior or emotional problems? If yes, please describe: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

10. List surgeries or hospitalizations: _____

FAMILY HISTORY:

1. Check all that apply:

<input type="checkbox"/> Migraine	<input type="checkbox"/> Depression
<input type="checkbox"/> Sinus Headaches	<input type="checkbox"/> Seizures
<input type="checkbox"/> Other Headaches	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Stroke in Children
<input type="checkbox"/> Relatives with Migraine: _____	

DETAILED DESCRIPTIONS OF MOST RECENT HEADACHES:

1. Describe in detail child's activities on the most recent day with headache (start from awakening to bedtime): _____

2. Describe in detail child's activities on the most recent day of school missed due to headache (start from awakening to bedtime): _____

3. Medications used: Include name, dose, tablet strength and did it work? _____
