

Headache/Migraine Patient Intake Form

If you have any questions about your headaches/migraines, talk to your doctor

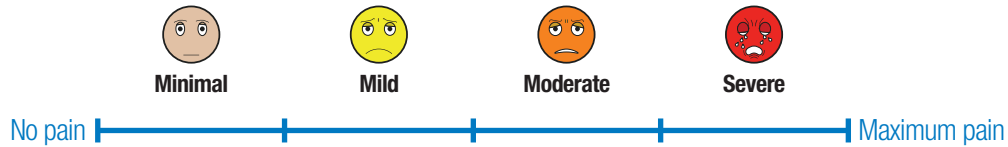
First name _____ Middle _____ Last name _____

DOB _____ Today's date _____ Years experiencing headache/migraine _____

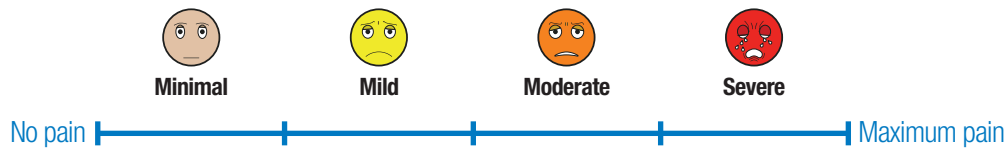
Headache/Migraine Intensity

Using the face icons as a guide, place an **X** on each line to indicate your headache/migraine intensity.

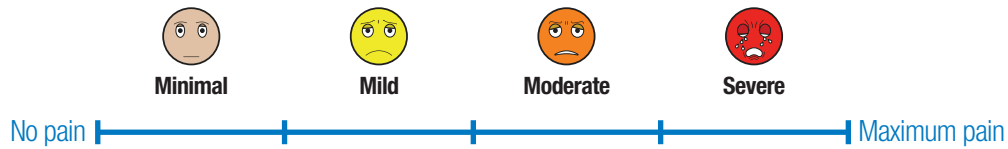
1. How strong is your **headache/migraine** intensity today?



2. How strong is the pain intensity during your **least severe** headache day?



3. How strong is the pain intensity during your **most severe** migraine day?



Headache/Migraine Frequency

1. On average, how many **days per month** have you had **headache/migraine** in the past 3 months?

Headache days: _____

(Less severe headaches still count)

Migraine days: _____

(These days often include symptoms like nausea and pain in 1 side of the head)

2. On average, how many **months** have you had this many headaches/migraines in the last year?

0-3 months

4-6 months

7-9 months

10-12 months

3. On average, how many **days per month** are you completely **headache-/migraine-free**? (No headache or migraine at all.)

Headache-free days: _____

Migraine-free days: _____

4. On average, what is the **duration** of your headache/migraine?

Fewer than 4 hours

4 or more hours

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Headache/Migraine Features

1. How would you **characterize** your typical headache/migraine? (Circle all that apply.)



Throbbing



Pressure



Sharp/stabbing



Tightness



Burning

2. What **symptoms** do you usually have during your typical migraine? (Circle all that apply.)



Nausea



Vomiting



Sensitivity to light



Sensitivity to sound



Pain on one side

3. On average how many **days per month** do you have 1 or more migraine symptoms?

4. On average how many **days per month** are you completely **symptom-free**? (No symptoms at all.)

5. Have you experienced any of the following symptoms **before a migraine**?



Visual disturbances



Numbness



Difficulty talking

6. On average, how many **days per week** do you use **acute medication** to treat migraine symptoms?

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Headache/Migraine Effects on Daily Life

Using the face icons as a guide, place an **X** on each line to indicate how much your headaches/migraines affect your daily life.

Write the approximate number of days per month you experience the situations described in each row.

1. How often do you need to go to a **dark room** because of your headaches/migraines?



Days per Month

2. How often do headaches/migraines **limit your ability** to complete tasks such as errands or household chores?



3. How often do you **miss work or school** due to headaches/migraines?



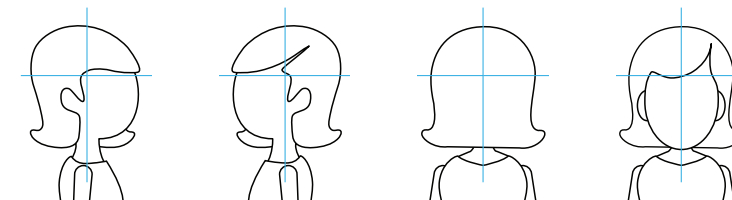
4. How often do you **miss social, family, or leisure activities** due to headaches/migraines?



5. How many times in the **last year** did you **go to the ER** because of headaches/migraines?

Headache/Migraine Location

1. Place an **X** on the images below to indicate where your headaches/migraines **originate most frequently**. (Mark all that apply.)



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Headache/Migraine Treatments

Preventive Treatments ^{1-3,*}	Treatment Name (Write in the treatments you've taken)	Dose (If you remember)	Results/Tolerability (Write in how well it worked and why you stopped taking it, if applicable)
Antidepressants (eg, amitriptyline, [†] <i>Effexor XR</i> [®] /venlafaxine [®])			
Antiseizure medications (eg, <i>Depakote</i> [®] /divalproex sodium, <i>Qudexy XR</i> [®] / <i>Topamax</i> [®] / <i>Trokendi XR</i> [®] /topiramate, valproic acid)			
Beta-blockers (eg, metoprolol, [†] nadolol, [†] propranolol, <i>Tenormin</i> [®] /atenolol, [†] timolol)			
Calcium channel blockers			
Other			

*Preventive treatments are taken on a schedule to prevent headaches/migraines before they even start. [†]Not FDA approved for the prevention of migraine.

1. Circle a face below to indicate how your headache/migraine **preventive treatments** have been working over the **past 3 months**.



Very well



Well



Average



Not well



Not at all

Acute Treatments [†]	Treatment Name (Write in the treatments you've taken)	Dose (If you remember)	Results/Tolerability (Write in how well it worked and why you stopped taking it, if applicable)
Analgesics/NSAIDs (eg, acetaminophen, aspirin, diclofenac, ibuprofen, naproxen, etc)			
Ergot alkaloid derivatives (eg, ergotamine, dihydroergotamine)			
Triptans (eg, rizatriptan, sumatriptan, zolmitriptan, etc)			
Opioids			
Other			

[†]Acute treatments are taken after a headache/migraine has started, to help reduce pain.

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	Baseline	Current (For re-authorization)	Reduction From Baseline (For re-authorization)			
Headache days/month						
Migraine days/month						
Headache hours/day						
Disability due to headache/migraine:						
Diagnosis of Chronic Migraine			Check One			
G43.709 —Chronic migraine without aura, not intractable, without status migrainosus						
G43.719 —Chronic migraine without aura, intractable, without status migrainosus						
G43.701 —Chronic migraine without aura, not intractable, with status migrainosus						
G43.711 —Chronic migraine without aura, intractable, with status migrainosus						
Other:						
Drug Name	Dose	Outcome				
		<input type="checkbox"/> Effective	<input type="checkbox"/> Suboptimal	<input type="checkbox"/> Intolerant	<input type="checkbox"/> Contraindicated	<input type="checkbox"/> Failed
		<input type="checkbox"/> Effective	<input type="checkbox"/> Suboptimal	<input type="checkbox"/> Intolerant	<input type="checkbox"/> Contraindicated	<input type="checkbox"/> Failed
		<input type="checkbox"/> Effective	<input type="checkbox"/> Suboptimal	<input type="checkbox"/> Intolerant	<input type="checkbox"/> Contraindicated	<input type="checkbox"/> Failed
		<input type="checkbox"/> Effective	<input type="checkbox"/> Suboptimal	<input type="checkbox"/> Intolerant	<input type="checkbox"/> Contraindicated	<input type="checkbox"/> Failed

Physician signature: _____ Date: _____