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?

   Minimal  |  Mild  |  Moderate  |  Severe  
   No pain  |          |          | Maximum pain

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

   Minimal  |  Mild  |  Moderate  |  Severe  
   No pain  |          |          | Maximum pain

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

   Minimal  |  Mild  |  Moderate  |  Severe  
   No pain  |          |          | Maximum pain

Headache/Migraine Frequency

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

   Headache days: _____  Migraine days: _____
   (Less severe headaches still count) (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
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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Using the face icons as a guide, place an X on each line to indicate how much your headaches/migraines affect your daily life.

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

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?

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Reference:


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### Headache/Migraine Treatments

#### Preventive Treatments

<table>
<thead>
<tr>
<th>Treatment Name</th>
<th>Dose</th>
<th>Results/Tolerability</th>
</tr>
</thead>
</table>
| **Antidepressants**  
(e.g., amitriptyline, Effexor® XR, venlafaxine) | | |
| **Antiseizure medications**  
(e.g., Depakote®/divalproex sodium, Qudexy® XR/Topamax®/Trokendi XR/Topiramate, valproic acid) | | |
| **Beta-blockers**  
(e.g., metoprolol, nadolol, propranolol, Tenormin®/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](image1)  ![Well](image2)  ![Average](image3)  ![Not well](image4)  ![Not at all](image5)

#### Acute Treatments

<table>
<thead>
<tr>
<th>Treatment Name</th>
<th>Dose</th>
<th>Results/Tolerability</th>
</tr>
</thead>
</table>
| **Analgesics/NSAIDs**  
(e.g., acetaminophen, aspirin, diclofenac, ibuprofen, naproxen, etc) | | |
| **Ergot alkaloid derivatives**  
(e.g., ergotamine, dihydroergotamine) | | |
| **Triptans**  
(e.g., zolmitriptan, sumatriptan, zolmitriptan, etc) | | |
| **Opioids** | | |
| Other | | |

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

### FOR OFFICE USE ONLY

<table>
<thead>
<tr>
<th>Diagnosis of Chronic Migraine</th>
<th>Check One</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G43.709</strong>—Chronic migraine without aura, not intractable, without status migrainosus</td>
<td></td>
</tr>
<tr>
<td><strong>G43.719</strong>—Chronic migraine without aura, intractable, without status migrainosus</td>
<td></td>
</tr>
<tr>
<td><strong>G43.701</strong>—Chronic migraine without aura, not intractable, with status migrainosus</td>
<td></td>
</tr>
<tr>
<td><strong>G43.711</strong>—Chronic migraine without aura, intractable, with status migrainosus</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dose</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| | | Effective  
Suboptimal  
Intolerant  
Contraindicated  
Failed |
| | | Effective  
Suboptimal  
Intolerant  
Contraindicated  
Failed |
| | | Effective  
Suboptimal  
Intolerant  
Contraindicated  
Failed |

Physician signature: ____________________________  Date: ____________

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