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?

   No pain __________  Minimal __________  Mild __________  Moderate __________  Severe __________  Maximum pain

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

   No pain __________  Minimal __________  Mild __________  Moderate __________  Severe __________  Maximum pain

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

   No pain __________  Minimal __________  Mild __________  Moderate __________  Severe __________  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
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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

### 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.

1. How often do you need to go to a dark room because of your headaches/migraines?
   - Never
   - Sometimes
   - Often
   - Always

2. How often do headaches/migraines limit your ability to complete tasks such as errands or household chores?
   - Never
   - Sometimes
   - Often
   - Always

3. How often do you miss work or school due to headaches/migraines?
   - Never
   - Sometimes
   - Often
   - Always

4. How often do you miss social, family, or leisure activities due to headaches/migraines?
   - Never
   - Sometimes
   - Often
   - Always

5. How many times in the last year did you go to the ER because of headaches/migraines?
   - Never
   - Sometimes
   - Often
   - Always

### Headache/Migraine Location

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

### References:

Note: This form provides information commonly used by payer plans to determine prior authorization. It is intended for reference only and does not guarantee approval. Nothing in this document is intended to serve as reimbursement or legal advice, a guarantee of coverage, or a guarantee of payment for treatment. Please be sure to check payer policies for the most up-to-date information. The decisions about which code to report should be made by the provider/practitioner considering the clinical facts, circumstances, and applicable coding rules, including the requirement to code to the highest level of specificity.
### Headache/Migraine Patient Intake Form

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

#### Headache/Migraine Treatments

<table>
<thead>
<tr>
<th>Preventive Treatments</th>
<th>Treatment Name</th>
<th>Dose</th>
<th>Results/Tolerability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antidepressants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(eg, amitriptyline, Effexor XR†/venlafaxine)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Antiseizure medications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(eg, Depakene®/divalproex sodium, Qualumin® XR/Topamax®/ Trokendi XR®/topiramate, valproic acid)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Beta-blockers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(eg, metoprolol, nadolol, propranolol, Tenormin®/atenolol, timolol)</td>
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</tr>
<tr>
<td><strong>Calcium channel blockers</strong></td>
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<td></td>
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<tr>
<td><strong>Other</strong></td>
<td></td>
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</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>Very well</th>
<th>Well</th>
<th>Average</th>
<th>Not well</th>
<th>Not at all</th>
</tr>
</thead>
</table>

#### Acute Treatments

<table>
<thead>
<tr>
<th>Acute Treatments</th>
<th>Treatment Name</th>
<th>Dose</th>
<th>Results/Tolerability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Analgesics/NSAIDs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(eg, acetaminophen, aspirin, diclofenac, ibuprofen, naproxen, etc)</td>
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<tr>
<td><strong>Ergot alkaloid derivatives</strong></td>
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<td></td>
<td></td>
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<tr>
<td>(eg, ergotamine, dihydroergotamine)</td>
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<tr>
<td><strong>Triptans</strong></td>
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<tr>
<td>(eg, eletriptan, sumatriptan, zolmitriptan, etc)</td>
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<tr>
<td><strong>Opioids</strong></td>
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<tr>
<td><strong>Other</strong></td>
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</tr>
</tbody>
</table>

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

#### FOR OFFICE USE ONLY

<table>
<thead>
<tr>
<th>Headache days/month</th>
<th>Migraine days/month</th>
<th>Disability due to headache/migraine:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

#### Diagnosis of Chronic Migraine

<table>
<thead>
<tr>
<th>G43.709</th>
<th>G43.710</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic migraine without aura, not intractable, without status migrainosus</td>
<td>Chronic migraine without aura, intractable, without status migrainosus</td>
</tr>
</tbody>
</table>

Other: 

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dose</th>
<th>Outcome</th>
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<tbody>
<tr>
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Physician signature: __________________________ Date: ____________

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