

# COLUMBIA HEADACHE CENTER

## Initial Consultation Form

**Name:**

**Date:**

**Date of birth:**

**Age:**

**Address:**

**Home Telephone:**

**Work Telephone:**

**Fax Number:**

**Height:**

**Weight:**

**Right handed or Left handed:**

**Referring Doctor:**

**Address:**

**Telephone:**

**Fax:**

**Reviewed with the patient on** \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_

THE FOLLOWING QUESTIONS ARE ABOUT YOUR HEADACHES:

At what age did you have the very first headache you can remember:

0-10      10-20      20-30      30-40      40-50      50-60      >60

Describe any details of that headache that you can recall:

Have they changed: Y N      How:  
When:

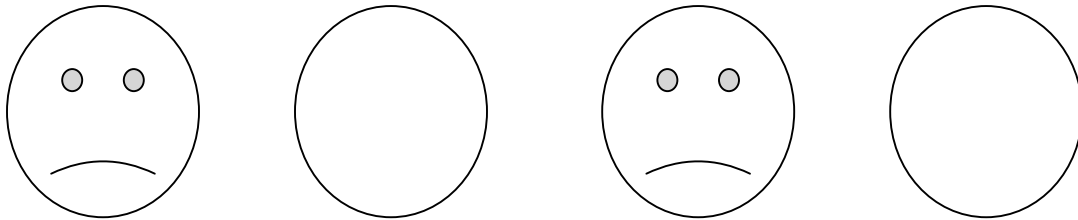
About how many days of **any kind** of headache do you have **each month**, even mild ones:

About how many days **each month** do you have a headache that keeps you from activities:

How would describe the pain of your most serious headaches: (circle one or several)

throbbing      pulsating      pounding      constant  
tight      pressure      sharp      grinding  
vise-like      hat-band      tender      other:

On the following figures, shade in the area(s) where you have been having head pain. Use one or more of the figures as needed for different kinds of head pain. Indicate right and left.



Are your headaches related to hormonal changes (women):

Are your headaches worse at any particular time of the week:

At what time of day does the pain usually begin:

no specific time      12-5 AM      5-8 AM      8-12 AM  
1-3 PM      3-5 PM      5-9 PM      9-12 PM

Do you have any warning signs **before** the start of a headache: Y N

Describe:

Circle any of the following symptoms you have with your headaches:

Neck pain      Nausea/vomiting      Light sensitivity      Dizziness  
Motion sickness      Sound sensitivity      Numbness      Weakness      Fever  
Other:

Have you ever been treated for headaches: Y N

What kind of headaches were you told you have:

Circle any of the following tests done at any time in the past, and add the date it was done:

MRI head      MRA head      CT scan head      Spinal tap      Formal eye test  
Blood tests for :    Thyroid disorder      Anemia      Diabetes      Clotting abnormalities

Is your head pain triggered by any of the following (Circle):

Change in weather      Caffeine      Smoking (yours or others)      Skipping meals

Lack of sleep      Fatigue      Stress/intense emotion      End of stress      Odors

Exertion (weight-lifting, running, sex, etc.)

Alcohol; what kind:

Foods; what kind:

Other; describe:

WHICH OF THE FOLLOWING MEDICINES HAVE YOU TRIED FOR HEADACHES (any kind): (circle)

\* **Star those which helped, even for a while.**

Anaprox	Darvocet	Fioricet	Oxygen	Talwin
Aspirin	Darvon	Fiorinal	Oxycodone	Topamax
Axert	Decadron	Flexeril	Pamelor	Tylenol
Amerge	Decongestants	Frova	Panadol	Valium
Aleve	DHE-45	Ibuprofen	Percocet	Verapamil
Axotal	Demerol	Imitrex	Percodan	Vicodin
Amitriptyline	Depakote	Inderal	Percogesic	Vivactyl
Antihistamines	Desyrel	Lamictal	PhrenilinForte	Wigraine
Anacin	Dilantin	Lidocaine	Propranolol	Xanax
Bellergal	Doxepin	Lithium	Relpax	Zanaflex
Botox	Empirin	Maxalt	Robaxin	Zomig
Bufferin	Esgic	Midrin	Sansert	Zonegran
Calan	Ergostat	Motrin	Soma	Others:
Codeine	Excedrin	Naprosyn	Stadol	
Cafergot	Elavil	Neurontin		
		Narco		

HAVE YOU TRIED ANY OF THE FOLLOWING ALTERNATIVE TREATMENTS: (circle)

Biofeedback      Acupuncture      Chiropractic      Relaxation Techniques      Herbal Supplements      Physical Therapy

LIST ALL THE **HEADACHE** MEDICATIONS YOU ARE NOW TAKING (over the counter or prescribed):

Drug Name                      Strength (Mg)                      #/Day                      #/Month

GENERAL MEDICAL HISTORY:

Do you now have, or have you ever had, any of the following (circle Y or N):

- |   |   |   |   |   |  |
|---|---|---|---|---|--|
| Y | N | Head or neck injury, even if minor,<br>Describe injury: | Y | N | Skin rash  |
| Y | N | Loss of consciousness                                   | Y | N | Anemia   |
| Y | N | Brain infection   | Y | N | Bleeding/clotting problems                                   |
| Y | N | Seizures  | Y | N | Bruising   |
| Y | N | High blood pressure                                     | Y | N | Depression   |
| Y | N | Palpitations  | Y | N | Anxiety  |
| Y | N | Chest pain  | Y | N | Panic attacks  |
| Y | N | Other heart disease                                     | Y | N | Other psychiatric problem                                    |
| Y | N | Kidney disease  | Y | N | Cancer or tumor anywhere                                     |
| Y | N | Urinary tract disease                                   | Y | N | Motion sickness  |
| Y | N | Asthma  | Y | N | Vertigo/dizziness  |
| Y | N | Chronic cough   | Y | N | Lymes Disease  |
| Y | N | Bronchitis  | Y | N | Chronic Fatigue  |
| Y | N | Tuberculosis  | Y | N | Fibromyalgia   |
| Y | N | Sinus problems  | Y | N | Epstein Barr   |
| Y | N | Birth abnormality                                       | Y | N | Teeth grinding or clenching                                  |
| Y | N | Skin spots  | Y | N | Allergies. Describe:   |
| Y | N | Ulcers  |   |   |  |
| Y | N | Heartburn/Reflux  |   |   |  |
| Y | N | Stomach pain  | Y | N | Any other condition for which<br>you are under medical care? |
| Y | N | Constipation  |   |   |  |
| Y | N | Diarrhea  |   |   |  |
| Y | N | Diabetes Mellitus                                       |   |   |  |
| Y | N | Abnormal blood sugar.                                   | Y | N | Any surgery, with dates:                                     |
| Y | N | Thyroid disease   |   |   |  |
| Y | N | Recent weight change                                    |   |   |  |
| Y | N | Frequent infections                                     |   |   |  |
| Y | N | Cold sores (fever blisters)                             | Y | N | Unusual childhood illnesses.                                 |
| Y | N | Arthritis/joint pain.                                   |   |   |  |

Please list ALL prescription pills you now take for any medical condition (including birth control pills):

Please list ALL pills you take that do not require a prescription (vitamins, Tylenol, cold medicines, herbal supplements, etc, etc.):

- SLEEP: Is your sleep good? Y N
- How many hours do you sleep each night: 5 6 7 8 9 10 variable
- What time do you go to bed: How many nights a week do you go to bed later/earlier:
- How many minutes does it take you to fall asleep:
- How deep is your sleep: light medium heavy
- What time do you get out of bed: How many mornings do you get up later?
- Do you awaken refreshed: Y N
- Are you sleepy during the day or evening (might fall asleep if inactive, ex. watching TV): Y N
- Have you ever had any unusual sleep-related problems, in childhood or as an adult:
- Do you snore: Y N Have you ever awakened from sleep with a snort or gasp:
- Do you awaken during the night to urinate: Y N
- Do you have strange feelings in your legs when relaxing, trying to fall asleep, or on long trips:
- Does anyone in your family have sleeping problems of any sort: Y N
- If yes, describe:

\* FEMALES ONLY:

Age menstrual periods began: Were your periods regular through your life: Y N

Number of days between each period (from day 1 to day 1):

Bleeding is: Heavy Medium Light

Have you ever taken birth control pills: Y N

Are you now taking birth control pills: Y N

With birth control pills did you feel better worse the same

Which symptoms (if any) do (did) you have before your period:

Headache Irritability Depression

Sleepiness Insomnia Cramps Other:

Have you ever been pregnant: Y N If yes, how many times:

If yes, were your headaches better worse the same

Have you gone through menopause: Y N

Have you had any changes which you feel are pre-menopausal: Y N

If yes, what symptoms:

WHAT IS YOUR CURRENT LEVEL OF STRESS (circle 0 = no stress; 10 = catastrophic): 0 1 2 3 4 5 6 7 8 9 10

SOCIAL HISTORY:

Level of education:

Marital Status: Number of years of marriage, if still married:

With whom are you living: (list relationship and ages)

Are there any serious problems at home? Y N Describe (if yes):

What is your current occupation:

How many hours/ week do you work: Do you like your job?: Y N Maybe

Habits: How many cigars/ cigarettes do you smoke each day: 0 1-5 5-10 10-20 20+

How many alcoholic drinks do you consume each week: 0 1-3 4-5 5+

How many caffeinated drinks do you consume each day: 0 1-2 3-4 5-6 7+

Do you use any "recreational drugs":

How many hours do you exercise each week: Doing what:

Do you eat meals at regular intervals: Y N

Do you have any special dietary habits:

Do you eat much "junk food": Y N If "yes", what kind:

**FAMILY HISTORY:**

Mother:           Alive or deceased:  
                      Age now or at time of death:  
                      Medical conditions:  
Father:            Alive or deceased:  
                      Age now or at time of death:  
                      Medical conditions:  
Brothers:          How many:  
                      Alive or deceased:  
                      Age now or at time of death:  
                      Medical conditions:  
Sisters:           How many:  
                      Alive or deceased:  
                      Age now or at time of death:  
                      Medical conditions:  
Mother's mother:  Alive or deceased:  
                      Age now or at time of death:  
                      Medical conditions:  
Mother's father:  Alive or deceased:  
                      Age now or at time of death:  
                      Medical conditions:  
Father's mother:  Alive or deceased:  
                      Age now or at time of death:  
                      Medical conditions:  
Father's father:  Alive or deceased:  
                      Age now or at time of death:  
                      Medical conditions:  
Children:          How many  
                      Alive or deceased  
                      Age now or at time of death

Is there any further information NOT requested on this questionnaire that you think might be important to your diagnosis and treatment? If so, please give me your thoughts.

**FINALLY:**

May I release the information on this questionnaire to the referring physician and other physicians participating in your care?    Yes        No

If Yes, please sign and date: \_\_\_\_\_

**PLEASE COMPLETE THE NEXT TWO PAGES**

Emotions play a role in most illness, including headaches. If I know about these feelings I can help you more. This last questionnaire is designed to help me know how you feel. Read each item and underline, check or circle the reply which comes closest to how you have been feeling in the past few weeks. Your first response will be the most accurate.

I feel tense or wound up:

Most of the time  
A lot of the time  
Only occasionally  
Not at all

I feel cheerful:

Not at all  
Not often  
Sometimes  
Most of the time

I still enjoy the things I used to enjoy:

Definitely as much  
Not quite so much  
Only a little  
Hardly at all

I can sit at ease and feel relaxed:

Definitely  
Usually  
Not often  
Not at all

I get a sort of frightened feeling as if something awful is about to happen:

Very definitely and quite badly  
Yes, but not too badly  
A little, but it doesn't worry me  
Not at all

I feel as if I am slowed down:

Nearly all the time  
Very often  
Sometimes  
Not at all

I can laugh and see the funny side of things:

As much as I always could  
Not quite so much now  
Definitely not so much now  
Not at all

I get a sort of frightened feeling like "butterflies"

Not at all  
Occasionally  
Quite often  
Very often

I feel restless as if I have to be on the move:

Very much indeed  
Quite a lot  
Not very much  
Not at all

I have lost interest in my appearance:

Definitely  
I don't take as much care as I should  
I may not take quite as much care  
I take just as much care as ever

I look forward with enjoyment to things:

As much as I ever did  
Rather less than I used to  
Definitely less than I used to  
Hardly at all

I get sudden feelings of panic:

Very often indeed  
Quite often  
Not very often  
Not at all

Worrying thoughts go through my mind:

A great deal of the time  
A lot of the time  
From time to time but not too often  
Only occasionally

CIRCLE ALL THE K's:

K P

N Q 5 K M O

X K T K R B T K

K R F K B W Q S T Z

B K L Y R K Q K

T K R W H K

B K

DIVIDE EACH LINE IN HALF:

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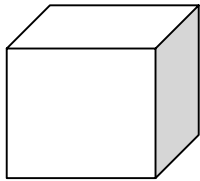
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WHAT DOES THIS PICTURE MAKE YOU THINK OF?



COPY THESE FOUR FIGURES:

1.

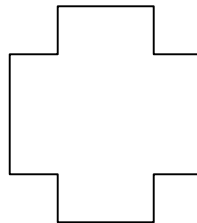


2.



3. X O X X O X X X O X X X X O

4.



DO THESE PROBLEMS:

$7 \times 5 =$

$6 + 17 =$

$60 \times 300 =$

$\$5.00 - \$1.69 =$

$20 - 8 \times 12 =$

$555 \div 5 =$