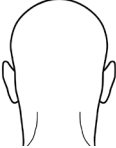





## PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

Please review and answer all parts of each question with our staff. Provide specific details/notes in the right hand column.

#	QUESTIONS																																													
1	<p>Have you been diagnosed by a health care provider with any of the following?</p> <p>» <input type="checkbox"/> Migraine    » <input type="checkbox"/> Chronic Daily Headache    » <input type="checkbox"/> Tension Headache    » <input type="checkbox"/> Cluster Headache    » <input type="checkbox"/> Medication Overuse Headache</p> <p>» <input type="checkbox"/> Menstrual Migraine    » <input type="checkbox"/> Trigeminal Neuralgia    » <input type="checkbox"/> Fibromyalgia    » <input type="checkbox"/> TMJ/D    » <input type="checkbox"/> Neck Problems    » <input type="checkbox"/> Other _____</p>																																													
2	<p>What sets off or triggers your pain or headaches?</p> <p>_____</p>																																													
3	<p>What tests have you had to help diagnose your headaches?</p> <p>» <input type="checkbox"/> MRI    » <input type="checkbox"/> CT Scan    » <input type="checkbox"/> Blood Tests    » <input type="checkbox"/> Hormone Testing</p>																																													
4	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Where are your pain/headaches located? (Mark Locations)</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;">  Back         </div> <div style="text-align: center;">  Front         </div> <div style="text-align: center;">  Right Side         </div> <div style="text-align: center;">  Left Side         </div> </div> </div> <div style="width: 45%;"> <p>On a scale of 1-10, how painful is it?</p> <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;">No Pain</div> <div style="flex-grow: 1; border-bottom: 1px solid black; position: relative;"> <div style="position: absolute; top: -10px; left: 0; right: 0; text-align: center;">Moderate Pain</div> <div style="position: absolute; top: -10px; right: 0; text-align: center;">Unbearable Pain</div> </div> <div style="margin-left: 10px;">10</div> </div> <div style="display: flex; justify-content: space-between; width: 100%; margin-top: 5px;"> <span>0</span><span>1</span><span>2</span><span>3</span><span>4</span><span>5</span><span>6</span><span>7</span><span>8</span><span>9</span><span>10</span> </div> </div> </div>																																													
5	<p>Describe the type of headache pain you feel most often:</p> <p>» <input type="checkbox"/> Achy    » <input type="checkbox"/> Throbbing    » <input type="checkbox"/> Stabbing    » <input type="checkbox"/> Other _____</p>																																													
6	<p>What other doctors have you seen for your pain, headaches, and/or migraines</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> GP / FAMILY DOCTOR / OB-GYN  <input type="checkbox"/> DENTIST (IF OTHER)  <input type="checkbox"/> NEUROLOGIST  <input type="checkbox"/> PSYCHIATRIST/PSYCHOLOGIST         </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> PHYSICAL THERAPIST  <input type="checkbox"/> CHIROPRACTOR  <input type="checkbox"/> EAR NOSE THROAT  <input type="checkbox"/> OTHER         </td> </tr> </table>	<input type="checkbox"/> GP / FAMILY DOCTOR / OB-GYN <input type="checkbox"/> DENTIST (IF OTHER) <input type="checkbox"/> NEUROLOGIST <input type="checkbox"/> PSYCHIATRIST/PSYCHOLOGIST	<input type="checkbox"/> PHYSICAL THERAPIST <input type="checkbox"/> CHIROPRACTOR <input type="checkbox"/> EAR NOSE THROAT <input type="checkbox"/> OTHER																																											
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7	<p>What medications do you use for headache, migraine, or pain relief?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:40%;">MEDICATION (NAME OF MEDICATION OR SUBSTANCE)</th> <th style="width:30%;">WHAT DOSE?</th> <th style="width:30%;">HOW OFTEN?</th> </tr> </thead> <tbody> <tr><td>Acetaminophen, Tylenol</td><td></td><td></td></tr> <tr><td>Ibuprofen, Advil, Motrin, Nuprin, etc..</td><td></td><td></td></tr> <tr><td>Naproxin, Aleve</td><td></td><td></td></tr> <tr><td>Rx pain medication ( )</td><td></td><td></td></tr> <tr><td>Rx pain medication ( )</td><td></td><td></td></tr> <tr><td>Rx muscle relaxant ( )</td><td></td><td></td></tr> <tr><td>Rx anxiety medication ( )</td><td></td><td></td></tr> <tr><td>Rx depression medication ( )</td><td></td><td></td></tr> <tr><td>Rx migraine medication ( )</td><td></td><td></td></tr> <tr><td>Medication for sleeping ( )</td><td></td><td></td></tr> <tr><td>Caffeine intake ( )</td><td></td><td></td></tr> <tr><td>Alcohol intake ( )</td><td></td><td></td></tr> <tr><td>THC, Medical Marijuana ( )</td><td></td><td></td></tr> <tr><td>Other: ( )</td><td></td><td></td></tr> </tbody> </table>	MEDICATION (NAME OF MEDICATION OR SUBSTANCE)	WHAT DOSE?	HOW OFTEN?	Acetaminophen, Tylenol			Ibuprofen, Advil, Motrin, Nuprin, etc..			Naproxin, Aleve			Rx pain medication ( )			Rx pain medication ( )			Rx muscle relaxant ( )			Rx anxiety medication ( )			Rx depression medication ( )			Rx migraine medication ( )			Medication for sleeping ( )			Caffeine intake ( )			Alcohol intake ( )			THC, Medical Marijuana ( )			Other: ( )		
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8	<p>Do you try non-medicating techniques for managing your pain or headaches?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>» <input type="checkbox"/> Yoga    » <input type="checkbox"/> Breathing Exercises    » <input type="checkbox"/> Cold Packs    » <input type="checkbox"/> Massage    » <input type="checkbox"/> Meditation    » <input type="checkbox"/> Physical Therapy    » <input type="checkbox"/> Hot Packs/ Hot Bath</p> <p>» <input type="checkbox"/> Acupuncture    » <input type="checkbox"/> Exercise    » <input type="checkbox"/> Other (please describe) _____</p>																																													