Headache/Migraine Patient Intake Form

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

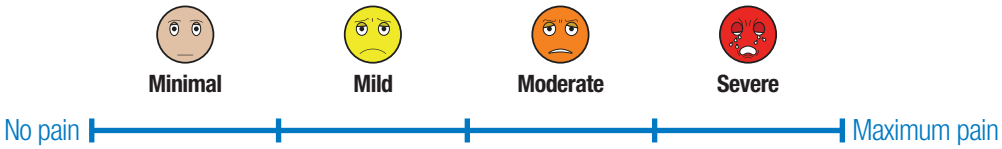
First name _____ **Middle** _____ **Last name** _____

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

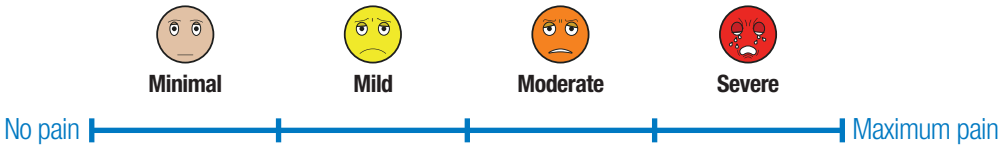
Headache/Migraine Intensity

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

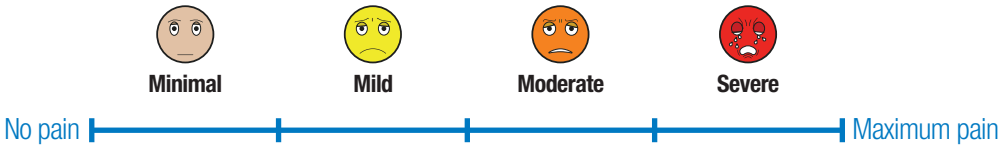
1. How strong is your **headache/migraine** intensity today?



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?

References: 1. Silberstein SD, Holland S, Freitag F, Dodick DW, Argoff C, Ashman E. Evidence-based guideline update: pharmacologic treatment for episodic migraine prevention in adults. *Neurology.* 2012;78(17):1337-1345. **2.** Goadsby PJ, Sprenger T. Current practice and future directions in the prevention and acute management of migraine. *Lancet Neurol.* 2010;9(3):285-298. **3.** Silberstein SD. Topiramate in migraine prevention: A 2016 perspective [published online ahead of print November 30, 2016]. *Headache.* doi:10.1111/head.12997.

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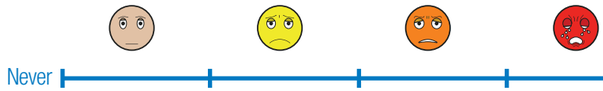
Headache/Migraine Effects on Daily Life

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

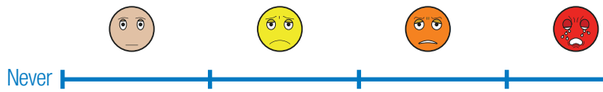
Write the approximate number of days per month you experience the situations described in each row.

Days per Month

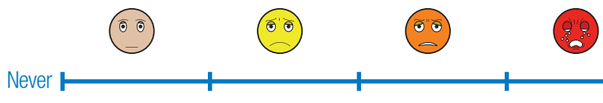
1. How often do you need to go to a **dark room** because of your headaches/migraines?



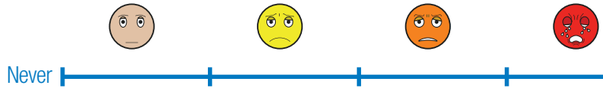
2. How often do headaches/migraines **limit your ability** to complete tasks such as errands or household chores?



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



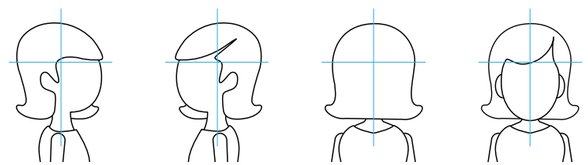
4. How often do you **miss social, family, or leisure activities** due to headaches/migraines?



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

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,† *Effexor XR*®†/venlafaxine†)			
Antiseizure medications (eg, *Depakote*®/divalproex sodium, *Qudexy*® *XR*†/*Topamax*®/ *Trokendi XR*®†/topiramate, valproic acid)			
Beta-blockers (eg, 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 **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
		☐ Effective ☐ Suboptimal ☐ Intolerant ☐ Contraindicated ☐ Failed
		☐ Effective ☐ Suboptimal ☐ Intolerant ☐ Contraindicated ☐ Failed
		☐ Effective ☐ Suboptimal ☐ Intolerant ☐ Contraindicated ☐ Failed
		☐ Effective ☐ Suboptimal ☐ Intolerant ☐ Contraindicated ☐ Failed

Physician signature: _____ Date: _____