ASBURY FAMILY Chiropractic

Headache Questionnaire

At what age did you have your first headache?_____ What year did your current headaches begin?_____

When was your last headache?_____

Are you ever free from pain completely? ☐ Yes ☐ No

Do you have more than one type of headache? ☐ Yes ☐ No

If yes, please describe them separately:_____

_____

How many headaches (any type) do you have each month?_____ How long do they last?_____

How would you describe the pain of your most serious headaches? ☐ **Throbbing** ☐ **Pulsating**

☐ **dull** ☐ **aching** ☐ **pressure-like** ☐ **sharp** ☐ **stabbing** ☐ **electric-like** ☐ **vise-like**

Direction of pain: ☐ from outside-in (compressing,stabbing) ☐ from inside-out (exploding, pushing out)

When you have a headache (and possibly after), does your scalp and face become sensitive to touch, and do you avoid putting on glasses, jewelry or combing your hair? ☐ yes ☐ No

What are your headaches brought on by? check all that apply

☐ **periods/hormonal changes** ☐ **exercise** ☐ **stress** ☐ **relaxation after stress**

☐ **change in weather** ☐ **alcohol** ☐ **bright light/glare** ☐ **odors** ☐ **smoke** ☐ **noise**

☐ **Lack of sleep** ☐ **Too much sleep** ☐ **Hunger** ☐ **food additives** ☐ **certain foods**

Do our headaches occur on any particular day of the week or time of the day? _____

_____

Do you have any warning signs before the start of a headache? ☐ yes ☐ No

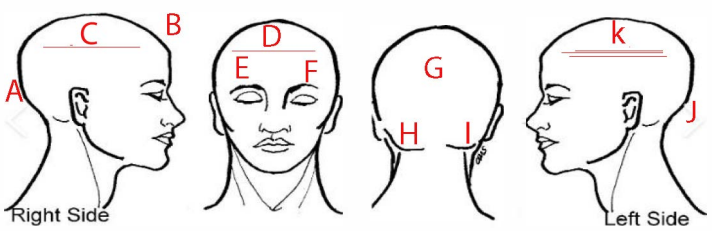
Describe:_____

Choose any/all of the following symptoms you have with your headaches: ☐ **Neck Pain** ☐ **Nausea**

☐ **vomiting** ☐ **light sensitivity** ☐ **dizziness** ☐ **noise sensitivity** ☐ **numbness** ☐ **Weakness**

☐ **fever** ☐ **confusion** ☐ **difficulty speaking** ☐ **tearing** ☐ **nasal congestion** ☐ **eyelid drooping**

☐ **Worsening of pain with movement** **other:**_____



Please list all of the letters from locations to the left that indicate where your pain from headaches are located:_____

_____

Drgregcrowley@gmail.com 2100 Asbury Road, Suite #6, Dubuque, IA 52001 563-582-3424

Please list all of your present medical problems and doctors you are seeing:_____

_____

_____

Please list all past medical problems, surgeries and hospital admissions:_____

_____

_____

Please list your allergies, if any:_____

_____

Amounts per day:

Alcohol:_____ Coffee:_____ Tea:_____ Tonic/Soda:_____ Water:_____

If you smoke, how many each day? _____ Recreational Drugs? ☐ yes ☐ no

What time of day do you go to sleep and wake up? Weekdays:_____ Weekends:_____

How many hours total do you sleep each night?_____

How many continuous hours of sleep do you get each night? _____

Which sleep routine represents you the best? ☐ Trouble falling asleep ☐ Trouble remaining asleep

☐ Trouble getting deep sleep ☐ Excessive sleepiness during the day ☐ Tossing and turning

☐ Snoring ____ Fatigued ____ Up several times at night ☐ Trouble getting back to sleep

Do you have a prior sleep diagnosis?_____ If yes, explain_____

Do you have a wearable device that will follow your sleep pattern (ie. apple watch or fitbit)?_____

Physical exercise/ frequency/duration:_____

Present work status:_____ Do you like your job? ☐ yes ☐ no ☐ not sure

If you have children, please list their ages:_____

Please list hobbies/recreational activities: _____

What is your stress level (0=no stress, 10= catastrophic): Home_____ Work_____ Social _____

Level of education:_____ Do you have pets? ☐ yes ☐ no

With whom are you living with (list relationship and age):_____

Are there any serious problems at home? ☐ yes ☐ no If yes, describe:_____

Is there a family history of (check all that apply):

☐ Headaches ☐ Heart Disease ☐ Alcoholism ☐ Tuberculosis ☐ Excessive Bleeding

☐ Seizures ☐ High Blood Pressure ☐ Goiter/Thyroid ☐ Mental Illness ☐ Cancer

☐ Strokes ☐ Arthritis ☐ Diabetes ☐ Obesity ☐ Sleep Disorders

☐ Other:_____

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Have you ever been treated for headaches? ☐ yes ☐ no

What kind of headaches were you told you have? _____

Have you had any tests done to diagnose your headaches? ☐ yes ☐ no

Describe: _____

Have you tried any of the following alternative treatments / supplements? ☐ **Biofeedback** ☐ **Chiropractic**
☐ **Acupuncture** ☐ **Physical Therapy** ☐ **Feverfew** ☐ **B2** ☐ **Magnesium**
☐ **MigreLief** ☐ **CoQ10** ☐ **Butterbur** ☐ **Petadolex** ☐ **Other**_____

List all of the headache medications and the amounts you are now taking (over the counter or prescribed):

_____

List all other medications you are taking for any reason:

_____

Have you had any of the following problems in the past 6 months? (check all that apply)

☐ Change in marital status	☐ Change in job/school	☐ New illness diagnosed
☐ Emotional trauma	☐ Change in smoking/drinking/diet	☐ Surgeries
☐ Fatigue	☐ Bruising	☐ Allergic reaction
☐ Skin rash	☐ Weight change __lbs loss__lbs gain	☐ Fever/chills
☐ High blood pressure	☐ Palpitations	☐ Breathing difficulty
☐ Chest pain	☐ Swelling	☐ Chronic cough
☐ Wheezing	☐ Bleeding/bruising	☐ Diarrhea
☐ Constipation	☐ Heartburn	☐ Stomach pain
☐ Nausea/vomiting	☐ Joint pain/swelling/redness	☐ Muscle aches
☐ Sexual dysfunction	☐ Breast lumps/discharge	☐ Irregular periods
☐ Symptoms of menopause	☐ PMS	☐ Bladder problems
☐ Cold extremities	☐ Leg/foot cramps	☐ Depression
☐ Anxiety/panic attacks	☐ Change in skin/hair	☐ Insomnia
☐ Excessive urination or thirst	☐ Leg restlessness	☐ Daytime sleepiness
☐ Snoring	☐ Teeth grinding/clenching	☐ Sleep apnea
☐ Seizures/shaking	☐ Headaches	☐ Back pain
☐ Neck Pain	☐ Decline in memory	☐ Weakness
☐ Numbness	☐ Hearing problems	☐ Vision problems
☐ Loss of consciousness	☐ Dizziness	☐ Dental problems
☐ Sinus problems	☐ Hoarseness	☐ Any other not listed

MIDAS Questionnaire / Migraine Disability Assessment

Patient Name:_____ Date:_____

This qustionnaire is used to determine the level of pain and disbility caused by you headaches, and helps your doctor find the best treatment for you.

Instructions: Please answer the following questions about all of your headaches over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months.

1) On yow many days in the last 3 months did you miss work or school because of your headaches: (If you do not attend work or school enter zero in the box to the right). ☐

2) How many days in the last 3 months was your productivity at work or school reduced half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school, enter zero in the box to the right) ☐

3) On how many days in the last 3 months did you not do household work because of your headaches? ☐

4) How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 3). ☐

5) On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches? ☐

A. On how many days in the last 3 months did you have a headache? ☐
(If headache lasted more than 1 day, count each day.)

B. On a scale of 0-10, on average, how painful were these headaches? ☐
(0= no paint at all, and 10 = pain which is as bad as it can be.)

During the past month:

1) Have you been bothered a lot by feeling sad, down or depressed? ☐ yes ☐ no
2) Have you been bothered a lot by a loss of interest or pleasure in your daily activities? ☐ yes ☐ no

For Men: When was the last time you had more than five drinks in one day?

☐ Never ☐ In the past three months ☐ over three months ago

For Women: When was the last time you had more than four drinks in one day?

☐ Never ☐ In the past three months ☐ Over three months ago.

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