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Follow-Up Headache Form

Patient's Name: ______________________________ **Date of Birth:** ____________________

Appointment Date: ____________________ **Appointment Time:** ________________

Pain Area & Intensity

Where does the headache pain start?

☐ temples ☐ back of head ☐ top of head

☐ forehead ☐ around eyes ☐ neck area

Does the pain move around? ☐ Yes ☐ No

If yes, please describe where: ______________________________

____

On a scale of 1-10 (*1 = slight, 10 = worse*), how severe is the pain? _________

Describe the pain (*check all that apply*): ☐ sharp ☐ dull ☐ pressure ☐ throbbing/pulsating ☐ band-like, squeezing ☐ other: ____________

Duration & Time-Frame

When do the headaches usually occur? (*check all that apply*): ☐ Early morning ☐ Mid-morning ☐ Afternoon ☐ Evenings ☐ At night/during sleep ☐ Other: ______________________________

How long do they usually last? ______ minutes ______ hours ______ days

How often do they occur? ______ times/week ______ times/month ______ times/month ☐ daily/constantly

Associated Symptoms

Please mark all that apply:

☐ vision problems	☐ light sensitivity	☐ sensation problems	☐ irritability	☐ fever
☐ blurred vision	☐ nausea	☐ difficulty talking	☐ runny nose	☐ anxiety
☐ loss of vision	☐ vomiting	☐ slurred speech	☐ loss of awareness	☐ fatigue
☐ loss of visual fields	☐ loss of appetite	☐ weakness	☐ cold or sweaty	☐ dizziness
☐ tearing	☐ smell sensitivity	☐ noise sensitivity	☐ pain when chewing	☐ lightheadedness

☐ eye redness ☐ neck stiffness or tenderness ☐ face looks pale or sweaty ☐ difficulty concentrating

☐ other: ______________________________

Additional Information

Please mark all possible triggers for the headaches: ☐ physical activity ☐ depression ☐ anxiety ☐ stress ☐ straining ☐ missing a meal ☐ little sleeping ☐ bending over ☐ menstrual cycles ☐ not staying hydrated ☐ other: __________

Are the headaches getting worse?

☐ Yes ☐ No

What makes the headaches better? ______________________________

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