

Name _____ Date _____ Patient # _____

THE CERVICOGENIC MIGRAINE CLINIC

Dr. Don Hackett, DC

HEADACHE QUESTIONNAIRE

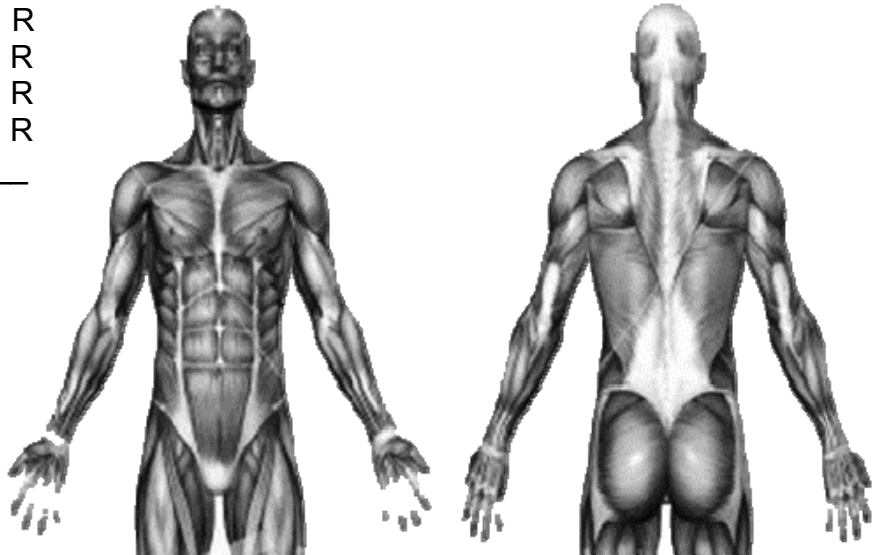
1. What type of treatment have you had in the past for your headaches?
___ Chiropractic ___ M.D. ___ P.T. ___ Other - Explain _____

2. Have you been diagnosed with migraine or tension headaches? Y N

3. If yes, by what type of doctor? ___ Orthopedic ___ Neurological
___ Primary Care Doctor Other _____

4. If you have been diagnosed with migraines are they:

- On one side of your head? L R
- Behind your eye(s)? L R
- Over your forehead? L R
- At the back of your head? L R
- All over your head? L R
- Other _____



5. How frequent are your headaches?
___ Daily ___ Weekly
Other _____

6. How frequent are your migraines?
___ Daily ___ Weekly
Other _____

7. What Medications do you take?
Over the counter (please list) _____
Prescription (please list) _____

8. Do the medications work? a. All of the time b. Some of the time
c. Rarely d. Never

9. How do you deal with your headaches/migraines?
___ Medications ___ Massage Other _____

10. Do you usually have to lie down to sleep in a dark room before your headaches/migraines resolve? Y N

11. How long do your headaches usually last? ___ Half a day ___ All day Other _____

12. Which do you have more frequently? ___Headache ___Migraine
13. Do you experience Auras prior to the onset of your migraine?
 ___ Flashing lights ___ Zigzag lines
 ___ Facial numbness Other _____
14. What previous assessments/tests have you had in regard to your headaches?
 ___ Orthopedic ___ Neurological
 ___ MRI ___ CAT Scan ___ EEG
 Other _____
15. Do you experience tinnitus (ringing in the ears)? Y N
16. Have you been diagnosed with TMJ/TMD (jaw pain)? Y N
17. How long have you been having headaches? ___ For the last year
 ___ For the last ___ years.
 ___ For as long as I can remember
 ___ Onset of puberty
 ___ As a child
18. What was the specific event that caused your headaches? (*circle/check any that apply*)
 a) Head trauma due to: ___ Car accident ___ Sporting accident Other _____
 b) The onset of menstruation Y N
 c) Birth trauma Y N
19. Do you have eye problems?
 a) Eye strain Y N
 b) Difficulty focusing Y N
 c) Must change prescription regularly Y N
20. I get car sickness:
 a) All the time as a passenger Y N
 b) As the driver Y N
 c) Driving is ok; symptoms increase as a passenger Y N
 d) I get nauseous as a passenger trying to read, but I'm ok if looking
 straight ahead Y N
 e) Cannot look out the side windows while moving, but Ok when
 looking straight ahead Y N
 f) Car sick as a child, but now only have trouble trying to read Y N
21. Cannot ride amusement rides due to:
 Vertigo Y N
 Nausea Y N
 Cannot focus eyes properly just after ride Y N
 Feeling of weakness Y N

Additional comments regarding the preceding information: _____

ARM & HAND

22. Have you been experiencing:
- | | | |
|---|---|---|
| Arm pain | Y | N |
| Numbness in the arm | Y | N |
| Hand pain | Y | N |
| Hand numbness | Y | N |
| Neck pain radiating into arm and hand | Y | N |
| Arm pain radiating into neck | Y | N |

23. How long have you been having this problem? _____

24. Do you think your neck pain and headache may be related to your arm pain? Y N

25. Does the problem come and go? Y N

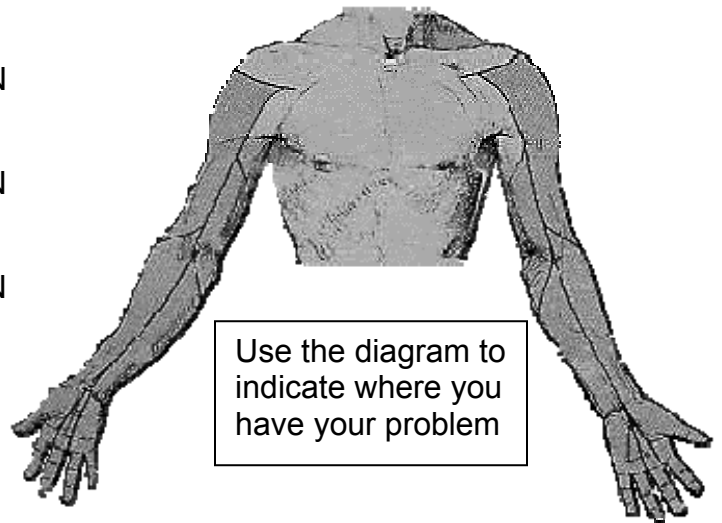
26. Does it happen with certain body positions? Y N
Explain _____

27. Does the problem resolve itself when you shake your arm and hand? .. Y N

28. Is the problem worse with you head leaning forward? Y N

29. Is the problem worse with your head leaning back? Y N

30. Do you have hip pain on the same or opposite side of the arm you are having a problem with?



FOR WOMEN ONLY

Is you migraine associated with your cycle? Y N
(If yes, please answer all that apply)

Just before menstruation? Y N

Just before ovulation? Y N

Do you experience cramping with your period or ovulation? Y N

Is there anything additional you feel would be beneficial for the doctor to know?

