THE PAIN RELIEF CENTER

7709 SAN JACINTO PLACE, SUITE 101 ▪ PLANO, TEXAS 75024
PH: (214) 709 - 1904 ▪ FAX: (214) 292 - 9329

MIGRAINE INSTITUTE

**NEW PATIENT QUESTIONNAIRE : HEADACHE SYMPTOMS**

At what age did your headaches begin? ____________ **YEARS OLD**

Do you have more than one type of headache? ☐ **YES** ☐ **NO**

***If yes***, answer the following questions about your ***most disabling headache type*** :

How often do your headaches occur? ☐ **DAILY** ☐ **WEEKLY** ☐ **MONTHLY** ☐ **OTHER** ____________

On average, how many days per month are you **Headache-Free**? ____________

How long do your headaches usually last? ____________ **HOURS** ____________ **DAYS** ____________ **WEEKS**

What part of your head / neck hurt? ____________

What do your headaches feel like? ☐ **SHARP** ☐ **ACHING** ☐ **THROBBING** ☐ **OTHER** ____________

How severe is your pain? ☐ **MILD** ☐ **MODERATE** ☐ **SEVERE**

Do you have warning signs before the pain starts (aura)? ☐ **YES** ☐ **NO** **DESCRIBE:** ____________

Do your headaches ever awaken you from sleep? ☐ **YES** ☐ **NO** **WHAT TIME?** ____________

On average, how many hours of sleep do you get per night? ____________ **HOURS / NIGHT**

Are your headaches **BETTER** at any particular time of the day? ☐ **YES** ☐ **NO** **WHAT TIME?** ____________

Are your headaches **WORSE** at any particular time of the day? ☐ **YES** ☐ **NO** **WHAT TIME?** ____________

Are your headaches affected by: ☐ **LYING DOWN** ☐ **SITTING** ☐ **STANDING**

Preferred position when you have a headache? ☐ **LAYING ON BACK** ☐ **LAYING ON SIDE** ☐ **STANDING** ☐ **OTHER** ____________

Have you had a **Brain CT** or **MRI**? ☐ **YES** ☐ **NO** Did you have images on CD / film with you today? ☐ **YES** ☐ **NO**

Have you ever had a ***concussion*** ? ☐ **YES** ☐ **NO**

Do you consume drinks / food that contain ***Nutrasweet*** / ***Equal*** / ***Aspartame*** ? ☐ **YES** ☐ **NO**

Have you been told that you ***stop breathing*** or ***gasp for air*** while sleeping? ☐ **YES** ☐ **NO**

Have you ever been diagnosed with **sleep apnea**? ☐ **YES** ☐ **NO**

Have you ever been **physically**, **emotionally**, or **sexually abused**? ☐ **YES** ☐ **NO**

Are you *currently* in an **abusive relationship**? ☐ **YES** ☐ **NO**

Do you get **any** of the following symptoms with your headaches? *(Check **ALL** that apply)*

| | | | | |
|---|---|---|---|---|
| ☐ **BLOODSHOT EYE (S)** | ☐ **DROOPY EYELID** | ☐ **NUMBNESS / TINGLING** | ☐ **SENSITIVITY TO NOISE** | ☐ **VOMITING** |
| ☐ **CONFUSION** | ☐ **DROWSINESS** | ☐ **RESTLESS** | ☐ **SENSITIVITY TO ODORS** | ☐ **WEAKNESS TO BODY / FACE** |
| ☐ **DIARRHEA** | ☐ **EXCESSIVE URINATION** | ☐ **RINGING IN EARS** | ☐ **SPINNING / DIZZINESS** | ☐ **WORSENS WITH ACTIVITY** |
| ☐ **DIFFICULTY SPEAKING** | ☐ **IMBALANCE** | ☐ **RUNNY NOSE** | ☐ **STUFFY NOSE** | |
| ☐ **DOUBLE VISION** | ☐ **NAUSEA / INABILITY TO EAT** | ☐ **SENSITIVITY TO LIGHT** | ☐ **TEARING FROM THE EYE(S)** | |

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Do you get **any** of the following symptoms, **HOURS TO DAYS**, **BEFORE** the headache starts?

☐ **FOOD CRAVINGS OR HUNGER** ☐ **UNEXPLAINED MOOD CHANGES** ☐ **UNCONTROLLABLE YAWNING** ☐ **EUPHORIA**

☐ **EXCESSIVE THIRST** ☐ **EXCESSIVE URINATION** ☐ **DROWSINESS** ☐ **OTHER** ______

Do any of the following **WORSEN** your headaches? ☐ **COUGHING** ☐ **LAUGHING** ☐ **LIFTING** ☐ **SEXUAL ACTIVITY** ☐ **SNEEZING** ☐ **STRAINING / BENDING DOWN**

**Caffeine Consumption:** ______ **CUPS / DAY**

**Type of Caffeine:** ☐ **COFFEE** ☐ **TEA** ☐ **SODA** ☐ **CHOCOLATE** ☐ **EXCEDRINE / MEDICATION**

**FEMALE ONLY**

Do any of the following affect your headache(s)? ☐ **BIRTH CONTROL PILL** ☐ **HORMONE REPLACEMENT THERAPHY** ☐ **OTHER** ______ ☐ **MENOPAUSE** ☐ **PREGNANCY**

Have your headaches caused problems in any of the following areas of your life?

☐ **JOB** ☐ **HOUSEWORK** ☐ **HOME LIFE** ☐ **RELATIONSHIPS** ☐ **SOCIAL LIFE** ☐ **SCHOOL** ☐ **LEGAL**

Do any family members have migraines or "sick headaches"? ☐ **YES** ☐ **NO** ***If so, whom?***

______

Do any family members have cluster headaches? ☐ **YES** ☐ **NO** ***If so, whom?***

______

What medication(s) have you tried for ***acute (symptomatic) treatment*** of heachache(s)? (*medication you took when you experienced a headache)* ***Include medications for nausea and over the counter medications*** . If you cannot remember, please contact your pharmacy or physician to obtain records and bring these with you (or attach).

| MEDICATION | DOSE (mg) | DATE STARTED | EFFECTIVE? | SIDE EFFECTS |
|---|---|---|---|---|
| | | | ☐ YES ☐ NO | |
| | | | ☐ YES ☐ NO | |
| | | | ☐ YES ☐ NO | |
| | | | ☐ YES ☐ NO | |
| | | | ☐ YES ☐ NO | |

What medication(s) have you tried for ***prevention of headache(s)*** (medication taken daily to prevent headaches)

| MEDICATION | DOSE (mg) | DATE STARTED | EFFECTIVE? | SIDE EFFECTS |
|---|---|---|---|---|
| | | | ☐ YES ☐ NO | |
| | | | ☐ YES ☐ NO | |
| | | | ☐ YES ☐ NO | |
| | | | ☐ YES ☐ NO | |
| | | | ☐ YES ☐ NO | |

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**ALLODYNIA QUESTIONNAIRE (ASC-12)**

How often do you experience ***increased pain*** or an ***unpleasant sensation*** on your skin ***during your most severe type of headache*** when you engage in each of the following?

| ACTIVITY | DOES NOT APPLY<br>*SCORE: 0* | NEVER<br>*SCORE: 0* | RARELY<br>*SCORE: 0* | LESS THAN HALF OF THE TIME<br>*SCORE: 1* | HALF OF THE TIME OR MORE<br>*SCORE: 2* |
|---|---|---|---|---|---|
| 1. Combing your hair. | | | | | |
| 2. Pulling your hair back *(e.g., ponytail)* | | | | | |
| 3. Shaving your face. | | | | | |
| 4. Wearing eyeglasses | | | | | |
| 5. Wearing contact lenses. | | | | | |
| 6. Wearing earrings. | | | | | |
| 7. Wearing a necklace. | | | | | |
| 8. Wearing tight clothing. | | | | | |
| 9. Taking a shower *(i.e., when the water hits your face).* | | | | | |
| 10. Resting your face or head on a pillow. | | | | | |
| 11. Exposure to heat *(e.g., cooking, washing your face with hot water, etc.)* | | | | | |
| 12. Exposure to cold *(e.g., using an ice pack, washing your face with cold water, etc.)* | | | | | |
| **TOTAL SCORE:**<br>*(TOTAL FROM EACH COLUMN)* | | | | | |
| **SUM OF TOTAL SCORES:** | | | | | |

| **FOR OFFICE USE ONLY:** | **0 - 2 NONE** | **3 - 5 MILD** | **6 - 8 MODERATE** | **9+ SEVERE** |
|---|---|---|---|---|

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## MIDAS DISABILITY ASSESSMENT

This questionnaire is used to determine the **level of pain and disability** caused by your **headaches** and helps your doctor find the ***best treatment plan for you.***

**INSTRUCTIONS:** Please answer the following questions about **ALL** of your headaches ***over the last 3 months*** **.**

For each question, write **ONE NUMBER**, ***not word or range*** , in the box next to each question. *If the activity does not apply to you* **, or you did not participate in the activity** within the past 3 months, write "**0**" in the box next to the question. If you do not keep a headache calendar, provide your best estimate.

| | ACTIVITY | NUMBER OF DAYS *(ONE NUMBER PER BOX)* |
|---|---|---|
| **1.** | How many days in the ***past 3 months*** did you ***miss work or school*** because of your headaches? *(If you did not attend work or school enter* ***zero*** *in the box.)* | |
| **2.** | How many days in the ***past 3 months*** was your ***productivity*** at work or school ***reduced by 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)* | |
| **3.** | On how many days in the ***past 3 months*** were you **unable to perform** household chores or duties due to your headaches? | |
| **4.** | How many days in the ***past 3 months*** was your ***productivity*** in household work ***reduced by half or more*** because of your headaches? *(* ***Do not include*** *days counted in* ***Question 3*** *, where you did not do household work)* | |
| **5.** | How many days over the ***past 3 months*** did you ***miss*** family, social, or ***leisure activities*** because of your headaches? | |
| | **TOTAL SCORE** *(Questions 1 through 5)* | |
| **A.** | On how many days in the ***past 3 months*** did you have a headache? *(If your headache lasted more than one day, count each day)* | |
| **B.** | On a **scale of 0 - 10**, where "**0**" = **No Pain** and "**10**" = **Severe Pain**, on average, how painful were these headaches? | |

**FOR OFFICE USE ONLY:** **0 - 5 LITTLE TO NONE** **6 - 9 MILD** **11 - 20 MODERATE** **21+ SEVERE**

## STOP-BANG QUSTIONNAIRE FOR SLEEP APNEA RISK

| *PLEASE FILL OUT STARRED (*) OR SHADED AREAS* | | YES | NO |
|---|---|---|---|
| * **S** | Do you snore loudly *(louder than talking or loud enough to be heard through closed doors)* ? | | |
| * **T** | Do you often feel ***tired*** , ***fatigued*** , or ***sleepy*** during the daytime? | | |
| * **O** | Has anyone ever observed you ***stop breathing*** during your sleep? | | |
| * **P** | Do you have or are you being treated for ***high blood pressure*** ? | | |
| | **TOTAL "YES"** | | |
| **B** | Is your body mass index greater than 35 kg/$m^2$? | | |
| * **A** | Are you older than **50 years**? | | |
| **N** | Does your neck measure more than 15 3/4 inches (40 cm) around? | | |
| * **G** | Is your gender male? | | |

**FOR OFFICE USE ONLY:** **High Risk of OSA:** **Answering "YES" TO 3 or More Items**