PHOENIX CHILDREN'S Medical Group

HEADACHE CLINIC INITIAL CONSULTATION

Apply Patient Label

Patient's Name: _____Today's Date_____/_____/_____

Date of Birth _____/_____/_____ Age _____ Sex: ☐ Male ☐ Female

Primary Care Physician: _____

Please answer the following questions to the best of your ability. This information will be used to assist in your child's care and may be used for study purposes. This is based on the original questionnaire that you filled out on the first visit.
If multiple choices are available, please check all that apply.

Medication Allergies? ☐ **Yes** or ☐ **No**

_____

Current Medications: (please include *pill size* and *exact schedule*)

_____

_____

_____

Up to Date on Immunizations? ☐ **Yes** or ☐ **No**

_____

Please Describe the Headaches:

- Type (describe briefly):
  _____
- Does the child have *more than one type* of headache?
  _____

1. At what age do you think the headaches began? _____
2. How long have you had headaches?
   _____
3. Do you think anything caused the headaches to begin? ☐ Yes ☐ No
   What? _____
4. Does your child act different BEFORE the headache starts? ☐ Yes ☐ No
   ☐ Tired ☐ Irritable ☐ Sunken Eyes ☐ Flushed Face ☐ "Not Right" ☐ Mood changes
5. Are there triggers that can start a headache? ☐ Yes ☐ No
   ☐ Stress ☐ Less sleep ☐ Food ☐ Skipping Meals ☐ Smells ☐ Light ☐ Noises
   ☐ Weather ☐ Menstruation ☐ Concentrating ☐ Caffeine ☐ Chocolate ☐ Other _____
6. How often does the headache occur?
   ☐ <1/month ☐ 1-3/month ☐ 1/week ☐ 2-3/week ☐ >3/week ☐ Daily
   ☐ Always ☐ Other _____
   Over the last three months, how many days PER MONTH did you have a headache? _____
   When was your LAST headache? _____
7. Are there any warnings that the headache is going to start (auras)? ☐ Yes ☐ No
   ☐ Visual ☐ Auditory ☐ Sensory ☐ Smell ☐ Taste Please explain: _____
8. Does your headache occur on one side of your head [_] and/or both sides [_]?
   On what parts of the head does the headache typically occur?
   ☐ Both temples/sides ☐ Left temple/side ☐ Right temple/side ☐ Front ☐ Top
   ☐ Back ☐ Around eyes ☐ Behind eyes ☐ All over ☐ Other _____
9. What is the pain of the headache like?
   ☐ Throbbing ☐ Squeezing ☐ Stabbing ☐ Pinching ☐ Pressure ☐ Burning ☐ Sharp
   ☐ Constant ☐ Dull ☐ "There" ☐ Other _____

10. What symptoms can occur with the headache?
☐ Nausea ☐ Vomiting ☐ Sensitivity to Light ☐ Sensitivity to sound ☐ Sensitivity to Smells
☐ Lightheadedness ☐ Spinning Sensation ☐ Tearing eyes ☐ Runny Nose ☐ Decreased Appetite
☐ Stomach Pain ☐ Fatigue ☐ Ringing in the Ears ☐ Changes in vision
☐ Confusion or Difficulty Thinking ☐ Difficulty Walking/Using Arms/ Talking ☐ Other _____

11. Do you experience any of these symptoms with many/most of your headaches?
☐ Transient Blindness ☐ Dark Blind Spots in your Vision ☐ Worsening While Lying Down
☐ Double Vision ☐ Worse with Coughing or Going to the Bathroom

12. How many MINUTES does it take the headache to reach maximum intensity? _____

13. How many HOURS does the headache last? Shortest: _____ Longest: _____ Average: _____

14. On average, how bad would you rate the headache (Please choose ONE)?
☐ Mild ☐ Moderate ☐ Severe

What is the severity on a scale of 0-10 (10 = worst)?
Mildest: _____ Worst: _____ Average: _____

15. During a bad headache: *Does your scalp hurt?* ☐ Yes ☐ No *Does your neck hurt?* ☐ Yes ☐ No
Does your hair hurt? ☐ Yes ☐ No *Do your arms or legs hurt?* ☐ Yes ☐ No
Does it hurt to do the following: ☐ Comb or Brush Hair ☐ Take a Shower (Hot/Cold) ☐ Wash Face
Does it hurt to wear: ☐ Ponytail ☐ Earrings ☐ Necklace ☐ Hat ☐ Backpack
☐ Glasses ☐ Contacts ☐ Headphones ☐ Tight Clothing
How soon after your headache starts do these symptoms begin? _____ minutes

16. Does the headache change your activity level (i.e. stop playing)? ☐ Yes ☐ No
Does activity or playing make the headache worse? ☐ Yes ☐ No
a. When you get a headache at school, at what level are you able to function?
☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%
b. When you get a headache playing at what level are you able to function?
☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%

17. Is there a pattern to the headaches? ☐ Yes ☐ No
What pattern? _____

18. Does the headache occur at a particular time of day? ☐ Yes ☐ No
☐ Waking up ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ While asleep

19. Are the headaches associated with a particular season? ☐ Yes ☐ No Which season? _____

20. Have other health care professionals seen you for headaches? ☐ Yes ☐ No
Who? _____

21. Have any studies or evaluations been performed? ☐ Yes ☐ No
☐ MRI ☐ CT/CAT scan ☐ Sinus X-ray ☐ EEG ☐ Other _____

22. Has the *frequency* of the headaches changed? ☐ Yes ☐ No
If so, how? _____

23. Has the *severity* of the headaches changed? ☐ Yes ☐ No
If so, how? _____

24. Has the *duration* of the headaches changed? ☐ Yes ☐ No
If so, how? _____

25. Have the *associated symptoms* changed? ☐ Yes ☐ No
If so, how? _____

26. What over-the-counter medications is your child using for his/her headache?

☐ Acetominophen (Tylenol^{R}) ☐ Ibuprofen (Advil^{R}/Motrin^{R}) ☐ Excedrin Migraine^{R} ☐ Aspirin
☐ Naproxen (Aleve^{R}) ☐ Other _____

27. What other methods do you use to help headaches?

☐ Sleep ☐ Cold Compress ☐ Hot Shower/Bath ☐ Relaxation ☐ Playing/Exercise
☐ Eating ☐ Other _____

28. Has anyone in the past every prescribed a DAILY medication to prevent headaches? ☐ Yes ☐ No

Which one(s)? _____

HEADACHE DISABILITY

The following questions try to assess how much the headaches are affecting day-to-day activity. Your answers should be based on the last three months. There is no "right" or "wrong" answers so please put down your best guess.

1a. How many full school days were missed in the last 3 months due to headaches? _____

1b. How many partial school days were missed in the last 3 months due to headaches (do not include full days counted in the first question)? _____

2. How many days in the last 3 months did you function at less than half your ability in school because of a headache (do not include days counted in the first two questions)? _____

3. How many days were you not able to do things at home (ie chores, homework, etc.) due to a headache? _____

4. How many days did you not participate in other activities due to headaches (i.e. play, go out, sports, etc.)? _____

5. How many days did you participate in these activities, but functioned at less than half your ability (do not include days counted in question number 4)? _____

Healthy Habits

Drinking: How much water do you drink a day? _____# of 8 oz glasses OR _____ Total ounces

Do you drink caffeine? ☐ Yes ☐ No How many days per week? _____

Are you drinking water in school? _____ With a water bottle? _____ Any problems? _____

Exercise: How many times a week are you exercising?_____

Eating: Are you skipping meals? ☐ Yes ☐ No Which meals? ☐ Breakfast ☐ Lunch ☐ Dinner

How many skipped meals per week? _____ Do you regularly eat vegetables? ☐ Yes ☐ No

Sleeping: How many hours of sleep are you getting a night? _____ Bedtime _____ Wake up time_____

Any difficulty sleeping? ☐ Yes ☐ No Time in minutes to fall asleep _____

Do you get more headaches on a certain day of the week? ☐ Yes ☐ No

Which days? ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Past Medical History:

Hospitalization or ER visit for headaches? ☐ Yes ☐ No

Date(s)_____

Any other hospitalizations? ☐ Yes ☐ No

_____

Any surgeries? ☐ Yes ☐ No

_____

Accidents (especially head trauma)? ☐ Yes ☐ No

_____

Illnesses (especially infection involving the brain)? ☐ Yes ☐ No

_____

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Birth History

Mother's PREGNANCY: **Any problems**? ☐ Yes ☐ No _____

Mom's previous pregnancies/miscarriages_____ Other children_____

DELIVERY: Hospital and City of Birth: _____

Any problems? ☐ Yes ☐ No _____

Full term or early? _____ How long labor? _____

Breech? _____ Forceps? _____C-section? _____

NEWBORN: **Any problems**? ☐ Yes ☐ No _____ Birth weight _____

Length _____ How long in hospital? _____ Intensive care? ☐ Yes ☐ No

Other Medical Diagnoses? ☐ Yes ☐ No

☐ Seizures ☐ ADD/ADHD ☐ Asthma ☐ Strokes ☐ Depression

☐ Anxiety ☐ Other _____

Recent travel outside this country? ☐ Yes ☐ No

_____

Exposures to toxic substances? ☐ Yes ☐ No

_____

Early Development:

Any concerns with early development? ☐ Yes ☐ No

IF SO, then give *approximate* age at which following appeared: Or check ☐ **ALL NORMAL**

Rolled Over _____ Sat Without Support _____

Walked _____ Toilet-Trained _____

Single Words _____ Talked in 3-Word Sentences _____

Regular or ***Special*** classes?

Any concerns with current school functioning? ☐ Yes ☐ No

Any therapies (PT, ST, OT, tutoring)? _____

Performance in school? _____ Behavior in school? _____

Reading level (if known) _____ Math level (if known) _____

Does your child have any of the following behavior concerns? (**Check all that apply**)

☐ Hyperactivity	☐ At home	☐ School
☐ Impulsivity	☐ At home	☐ School
☐ Moodiness	☐ At home	☐ School
☐ Short Attention Span	☐ At home	☐ School
☐ Poor Judgement	☐ At home	☐ School
☐ Distractibility	☐ At home	☐ School

Family History (biological parents):

Mother's name _____Age: _____ Health_____

Occupation _____

Father's name _____Age:_____ Health_____

Occupation _____

Brother(s) name _____Age: _____ Health_____

Sister(s) name _____Age: _____ Health_____

WHO in the family (if anyone) has similar headaches to the child? _____

If there is a **family history** of any of the following, please note:

☐ Headaches/Migraines	☐ Deafness	☐ Depression
☐ Diabetes	☐ Cancer	☐ Drug Abuse/Alcoholism
☐ Seizures/Epilepsy	☐ Tuberculosis	☐ Intellectual disability or Learning Disability
☐ Heart Disease	☐ Hypertension	☐ Brain tumor
☐ Thyroid	☐ Neuromuscular or other Neurological Disease	
☐ Sudden Death	☐ Early Heart Attack or Stroke/What Age ? _____	

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		HEADACHES (Any type)	MIGRAINES	TENSION HEADACHE	SINUS HEADACHE	Other medical or mental health concerns
FATHER						
MOTHER						
Siblings	Age					
BROTHER						
SISTER						
Dad's Father						
Dad's Mother						
Mom's Father						
Mom's Mother						
Aunts and Uncles	#					
Dad's brothers						
Dad's sisters						
Mom's brothers						
Mom's sisters						
Other_____						

Social History:

Who lives in the home with the child currently? _____

Please note the *biological* parents' status: ☐ Married/Living together ☐ Divorced/Separated

If divorced/separated, do both parents have equal custody? ☐ Yes ☐ No

Current School:

Name of school: _____ Grade: _____

School type: ☐ Public ☐ Private ☐ Charter ☐ Home-schooled ☐ College

Review of Systems:

If your child has any of the following concerns, please note if it is a problem ***NOW*** or in the ***PAST***:

General: ☐ Excessive Fatigue _____ ☐ Other _____

Eyes: ☐ Blurred Vision _____ ☐ Squinting _____ ☐ Double Vision _____
☐ Blind Spots _____ ☐ Loss of Vision _____ ☐ Crossed eyes _____
☐ Odd Eye Movements _____ ☐ Recent Eye Examination _____

ENT: ☐ Ringing in Ears _____ ☐ Hearing Problems _____ ☐ Ear Infections _____
☐ Draining Ears _____ ☐ Allergies _____ ☐ Other _____

Heart: ☐ Fainting _____ ☐ History of Murmur _____ ☐ Dizziness with Exercise _____ ☐ Other _____

Lungs: ☐ Asthma _____ ☐ Wheezing _____ ☐ Pneumonia _____
☐ Choking/Coughing _____ ☐ Other _____

Musculoskeletal: ☐ RIGHT or ☐ LEFT Handed ☐ Clumsiness _____ ☐ Fractures _____
☐ Muscle Weakness _____ ☐ Limping _____ ☐ Stumbling/Excessive Falling _____
☐ Bone Pain _____ ☐ Abnormality or Deformity of Bones or Joints _____ ☐ Scoliosis _____
☐ Other _____

Gastrointestinal: ☐ Nausea _____ ☐ Vomiting _____ ☐ Diarrhea _____
☐ Constipation _____ ☐ Blood in Stools/Black Stools _____ ☐ Other _____

- Do you think your child's *food choices* or *diet* contribute to the headaches? ☐ Yes ☐ No

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Genitourinary: ☐ Bladder or Kidney Infections _____ ☐ Blood in urine _____
☐ Painful or Frequent Urination _____ ☐ Other _____

Skin: ☐ Rashes _____ ☐ Birth marks _____ ☐ Eczema _____ ☐ Other _____

Sleep problems: ☐ Sleeplessness _____ ☐ Teeth Grinding _____
☐ Restless Sleeping _____ ☐ Excessive Daytime Sleepiness _____
☐ Bed Wetting _____ ☐ Night Terrors/Nightmares _____
☐ Sleepwalking _____ ☐ Snoring _____ ☐ Other _____

- Do you think that your child's headaches interfere with sleep? ☐ Yes ☐ No
- Do you think that *too little sleep* or *too much sleep* brings on your child's headaches? ☐ Yes ☐ No

Neurological: ☐ Dizziness _____ ☐ Lightheadedness _____ ☐ Jerks _____
☐ Abnormal Movements _____ ☐ Speech problems _____ ☐ Trouble Writing _____
☐ Trouble Thinking _____ ☐ Loss of any Previously Acquired Developmental Functions _____
☐ Convulsions _____ ☐ Seizures _____ ☐ Staring Spells _____
☐ Prior Head Injury With or Without Loss of Consciousness _____ ☐ Other _____

Psychiatric: ☐ Severe Mood Swings _____ ☐ Severe Behavioral Problems _____
☐ Depression (current or previous) _____ ☐ Prior Trauma or Abuse _____
☐ History of Seeing a Psychologist/Psychiatrist? _____ ☐ Other _____

Heme/Lymph: ☐ Anemia _____ ☐ Swollen Lymph Nodes _____ ☐ Other _____

Endocrine: ☐ Thyroid problems _____ ☐ Early Onset of Puberty (boys or girls) _____
☐ Excessive sweating _____ ☐ Excessive Thirst _____
☐ Excessive urination _____ ☐ Excessive Hunger _____
☐ Always Too Cold _____ ☐ Always Too Hot _____ ☐ Other _____

GIRLS: at what age was the first period? ☐ _____ Are they regular? ☐ Yes ☐ No ☐ Not Sure
Are your headaches WORSE with your periods? ☐ Yes ☐ No ☐ Not Sure ☐ N/A
If you haven't had a period OR they just started, do you have monthly headaches? ☐ Yes ☐ No ☐ Not Sure
_____Days Severity _____ Duration _____

Are there any other concerns that have not yet been addressed?

_____

_____

_____

_____ _____
Signature of Patient/Legally Authorized Representative **Date**

_____ _____
Printed Name of Patient/Legally Authorized Representative **Relationship to Patient**

_____ _____ _____
Practitioner Signature **Date** **Time**

_____
Practitioner Printed Name