Name _____ Date _____ Patient # _____

THE CERVICOGENIC MIGRAINE CLINIC

Dr. Don Hackett, DC

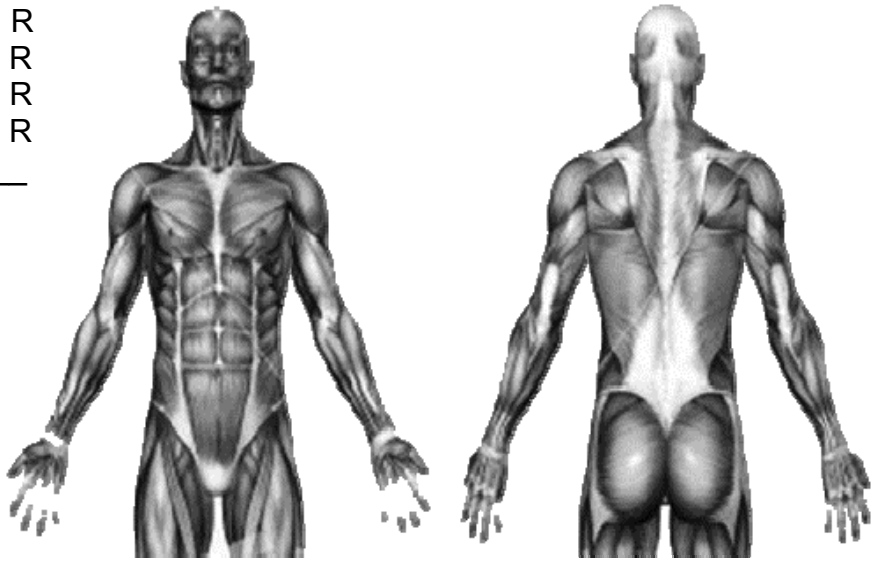
HEADACHE QUESTIONNAIRE

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

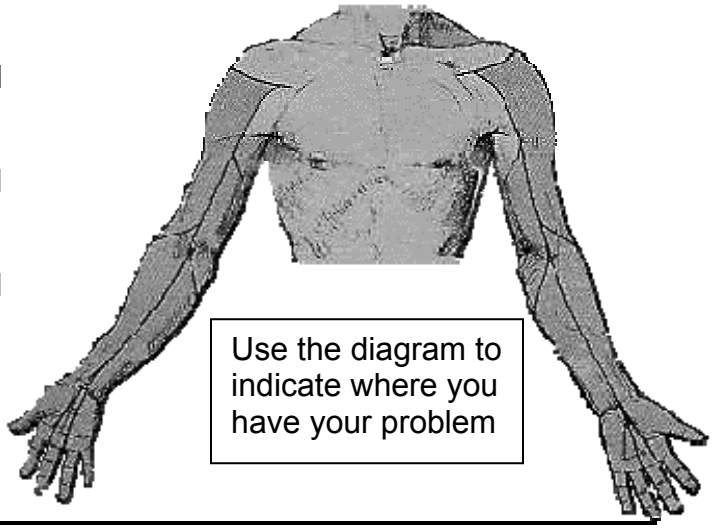
26. Does it happen with certain body positions? . . . . . Y N
    Explain _____

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? (If yes, please answer all that apply)	Y	N
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?

_____
_____
_____
_____
_____
_____