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Headache Patient Questionnaire

Name: _____ **Date of Birth** _____

Address: _____**City** _____ **State** _____**Zip** ____

Phone: _____

Do you suffer from headaches? **Yes** ☐ **No** ☐

Are they migraines? **Yes** ☐ **No** ☐

How many days of headache a month? _____

How severe on a scale of 0 to 10? _____

How many hours does your headache last each time? _____

Nausea? **Yes** ☐ **No** ☐

Sensitivity to light? **Yes** ☐ **No** ☐

What better describes your headache? **Pressure** ☐ **Pulsating** ☐

Is your headache on: **One side?** ☐ **Both sides?** ☐

List all medications used for headache/migraines:

_____

_____

Have you ever used Botox for migraine prevention? _____

Signature **Date**

_____ _____