Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Centre for Headache Intake Form**

Family Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency contact name & tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health coverage (circle): ODB Trillium Private Other\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **B. Over the *last 2 weeks* how often have you been bothered by the following problems?** | Not at all | Several days | More than half the days | Nearly every day |
| Feeling nervous, anxious or on edge | *0* | *1* | *2* | *3* |
| Not being able to stop or control worrying | *0* | *1* | *2* | *3* |
| Feeling down, depressed or hopeless | *0* | *1* | *2* | *3* |
| Little interest or pleasure in doing things | *0* | *1* | *2* | *3* |
| *PHQ-4 total score =* |  |  |  |  |

**A. During the *last 3 months*, did you have the following with your headaches?**

1. You felt nauseated or sick to your stomach? Yes No
2. Light bothered you (a lot more than when you didn’t have headaches)? Yes No
3. Your headaches limited your ability to work, study or do what you

needed to do for at least 1 day? Yes No

**C. Indicate/circle the response that best captures *a typical week*:**

1. How much water do you drink per day? *(Plain, non-flavoured)*

Less than 1.5 litres (6 cups) 1.5 litres (6 cups) or more

1. How many days per week do you drink caffeine? \_\_\_\_\_\_ How many cups per day? \_\_\_\_\_
2. How often in a week do you eat 12-15gms of protein for breakfast, within one hour of waking up?

Never Some of the days Everyday

1. Do you go to bed and wake up the same time every day? Yes No

Does your routine change on weekends/days off? Yes No

*If yes, explain:*  Up earlier Up later Napping

1. On average, how many days per week do you treat a headache (with prescription or over-the-counter medication)? *(do not include daily preventives)*

Never 1-2 days More than 3 days

List the medications used *(eg-Advil/Motrin, Excedrin, Tylenol+/-codeine, Fiorinal, 222’s, triptan etc.):*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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HeadacheIntakeForm\_March\_2018