PEAK NEUROLOGY
AND SLEEP MEDICINE, LLC

Headache/migraine patient intake form

If you have any questions about your headaches/migraines, talk to your medical provider

Name: _____ DOB: _____

Years experiencing headaches/migraine: _____

Headache/migraine frequency

About how many **days per month** are you completely **headache/migraine free** (no headache at all)? _____

On average, how many **hours per day** do your headaches/migraines last?

☐ 0-3 ☐ 4-7 ☐ 8-11 ☐ 12+

Over the past **3 months**, how has your headache/migraine frequency changed?

☐ Getting them more often ☐ Getting them less often ☐ No change

Headache/migraine symptoms

What symptoms do you **normally have** with your headaches/migraines? (check all that apply)

☐ Moderate or severe pain ☐ Sensitivity to light ☐ Sensitivity to sound ☐ Nausea

☐ Vomiting ☐ Pain on one side or in specific areas ☐ Vision changes

On average, how many **days per month** do you have one or more of these headache/migraine symptoms?

☐ 0-4 ☐ 5-9 ☐ 10-14 ☐ 15+

On a scale of **1-10** (1 being mild pain, 10 being worst pain imaginable), rate your typical headache/migraine: ____ /10

Do you experience any symptoms **prior to developing** a headache (aura)? If so, please describe briefly:

Have you identified **triggers** for headaches? (Exposure to bright lights, dehydration, etc.) If so, please describe briefly:

How headache/migraine affects your daily life

How many **days last month** did you miss work or school due to headaches/migraines?

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+

How many **days last month** did you cancel plans due to headaches/migraines?

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+

How many **times last year** did you go to the ER because of headaches/migraines?

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+

Headache/migraine treatments

Please list medications/medication history as completely as possible in the tables below:

Preventative treatment examples	Treatment name (Write in the treatments you've taken)	Dose (If you remember)	Results (Write in how well it worked and why you stopped taking it, if applicable)
Antidepressants (Eg. amitriptyline/Elavil, nortriptyline/Pamelor, Effexor XR/venlafaxine)			
Antiseizure medications (Eg. Depakote/divalproex sodium, Topamax/topiramate, valproic acid, gabapentin)			
Beta-blockers (Eg. metoprolol, propranolol)			
Calcium channel blockers (Eg. verapamil)			
Other (Botox injecctions, occipital nerve block, etc.)			

Over the past 3 months, how do you feel your headache/migraine preventive treatments are working?

☐ Not at all ☐ Not well ☐ Average ☐ Well ☐ Very well

Acute treatment examples	Treatment name (Write in the treatments you've taken)	Dose (If you remember)	Results (Write in how well it worked and why you stopped taking it, if applicable)
Analgesics/NSAIDs (Eg. acetaminophen/Tylenol, aspirin, ibuprofen/Motrin, naproxen/Naprosyn)			

If applicable, how often do you utilize analgesic/NSAID medications in **a typical week**? (Number of doses)

☐ 0 ☐ 0-1 ☐ 2-4 ☐ 4+

Triptans (Eg. sumatriptan/Imitrex, zolmitriptan/Zomig, rizatriptan/Maxalt)			

If applicable, how often do you utilize a triptan medication in **a typical week**? (Number of doses)

☐ 0 ☐ 0-1 ☐ 2-4 ☐ 4+

Opiate medications (Eg. oxycodone, Percocet, hydrocodone, Vicodin)			

Over the past 3 months, how do you feel your headache/migraine acute treatments are working?

☐ Not at all ☐ Not well ☐ Average ☐ Well ☐ Very well

Please list any other medications, supplements, vitamins, etc. in the space below:

Please return form to front desk/medical staff once complete.