Migraines and Headache History Assessment

Patient Details

Full Name

Date of Birth

Date of Assessment

Headache History

When did the headaches start?

How often do you have headaches?

How long do the headaches last?

Where is the pain located?

Describe the pain (e.g., throbbing, sharp):

Severity (1-10):

Associated Symptoms

Do you experience any of the following? (select all that apply)

- [ ] Nausea
- [ ] Vomiting
- [ ] Visual changes (Aura)
- [ ] Sensitivity to light

☐

Sensitivity to sound

☐

Other

If other, please specify:

Triggers

Do any factors trigger your headaches?

Relieving Factors

What helps to relieve your headaches?

Current and Past Treatments

Medications tried (past and present):

Other treatments (e.g., physical therapy, lifestyle changes):

Family History

Is there a family history of migraines or headaches?

Comments / Additional Notes