MANHATTAN
PAIN MEDICINE

Headache Intake Questionnaire

Please **Name** and **Describe** each different **Head, Neck** or **Face** pain:

1. _____
2. _____
3. _____
4. _____

Onset - How old were you when you first had a headache? _____

Trauma - Has there been any physical injury? (Concussion, whiplash, etc):

_____

Were any of the above pains ***new*** or ***worsened*** with trauma? (circle) 1 2 3 4

How many **days per week** do you have **NO pain** in the **head?** _____

Family - Who else in your family gets headaches? _____

Symptoms:

- ☐ Throbbing/Pulsating
- ☐ Icepick / Sharp Jabbing
- ☐ Electrical shocks
- ☐ Burning
- ☐ Skin/Hair hypersensitivity
- ☐ Light sensitivity
- ☐ Sound sensitivity
- ☐ Nausea
- ☐ Vertigo
- ☐ Lightheadedness
- ☐ Tinnitus / Pulsatile Tinnitus
- ☐ Whooshing
- ☐ Droopy eyelid
- ☐ Double Vision
- ☐ Blurry Vision
- ☐ Tearing / Nasal congestion
- ☐ Brain Fog
- ☐ Exercise Intolerance
- ☐ Positional Intolerance
- ☐ Difficulty swallowing
- ☐ Palpitations / POTS
- ☐ Jaw Pain
- ☐ Neck Pain

Triggers - Please list your most common triggers: _____

_____

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Medications - Which medications have you tried, and what was your response?

Antidepressants

- ☐ Amitriptyline/Elvail: _____
- ☐ Nortriptyline/Pamelor: _____
- ☐ Duloxetine/Cymbalta: _____
- ☐ _____ _____
- ☐ _____ _____

Antiseizure

- ☐ Topiramate/Topamax: _____
- ☐ Lamotrigine/Lamictal: _____
- ☐ Gabapentin/Neurontin: _____
- ☐ Pregablin/Lyrica: _____
- ☐ _____ _____
- ☐ _____ _____

Blood Pressure

- ☐ Propranolol: _____
- ☐ Atenolol: _____
- ☐ Candesartan: _____
- ☐ _____ _____
- ☐ _____ _____

CGRP

- ☐ Nurtec or Ubrelvy: _____
- ☐ Ubrelvy: _____
- ☐ Ajovy: _____
- ☐ Emgality: _____
- ☐ Aimovig: _____

Botox _____

Other notes: _____

_____

_____

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Procedures - What procedures have you had, and how did they affect each pain?

Procedure	1	2	3	4

Example Template - For Tracking Responses to Future Treatments

List Each Symptom	Medication 1	Diagnostic Block 1	PT	Medication 2	Diagnostic Block 2...
1					
2					
3					
4					