PHOENIX CHILDREN'S Medical Group

HEADACHE CLINIC INITIAL CONSULTATION

Apply Patient Label

Patient's Name: _____ Sex: M or F Age ____
Date of Birth: _____ Today's Date: _____
Who is the patient's primary doctor? _____

Please answer the following questions to the best of your ability. Please circle response if available. This information will be used to assist in your child's care and may be used for study purposes. If there is more than one type of headache (i.e. a frequent mild headache and a rarer severe headache), please describe the information for both. **If multiple choices are available, please circle all that apply**.

MEDICATION ALLERGIES? Yes or **No**_____
CURRENT MEDICATIONS: (please include *pill size* and *exact schedule*) _____
_____
_____
Up to date on IMMUNIZATIONS? **Yes** or **No** _____

PLEASE DESCRIBE THE HEADACHES:
>Age of onset of headaches: _____
>Type (describe briefly): _____
>Does the child have *more than one type* of headache? _____

1. Does your child act different BEFORE the headache starts? YES NO

Tired Irritable Sunken Eyes Flushed Face "Not Right" Mood changes

2. Are there triggers that can start a headache? YES NO
Stress Less sleep Food Skipping Meals Smells Light Noises Weather
Menstruation Concentrating Caffeine Chocolate Other _____

3. Are there any warnings that the headache is going to start (auras)? YES NO
Visual Auditory Sensory Smell Taste Other _____

4. Does your headache occur on one side of your head [_] and/or both sides [_]?
On what parts of the head does the headache typically occur?
Both temples/sides Left temple/side Right temple/side Front Top
Back Around eyes Behind eyes All over Other _____

5. What is the pain of the headache like?
Throbbing Squeezing Stabbing Pinching Pressure Burning Sharp
Constant Dull "There" Other _____

6. What symptoms can occur with the headache?
Nausea Vomiting Sensitivity to light Sensitivity to sound Sensitivity to smells
Lightheadedness Spinning sensation Tearing eyes Runny nose Decreased appetite
Stomach pain Fatigue Ringing in the ears Changes in vision
Confusion or difficulty thinking Difficulty walking/using arms/ talking
Other _____

7. How many MINUTES does it take the headache to reach maximum intensity? _____

8. How many HOURS does the headache last? Shortest: _____ Longest: _____ Average: _____

9. On average, how bad would you rate the headache (Please choose ONE)?
   Mild Moderate Severe

   What is the severity on a scale of 0-10 (10 = worst)?
   Mildest: _____ Worst: _____ Average: _____

10. During a bad headache: Does your scalp hurt? YES NO Does your neck hurt? YES NO
    Does your hair hurt? YES NO Do your arms or legs hurt? YES NO
    Does it hurt to do the following: Comb or brush hair Take a shower (hot/cold) Wash face
    Does it hurt to wear: Ponytail Earrings Necklace Hat Backpack
    Glasses Contacts Headphones Tight clothing
    How soon after your headache starts do these symptoms begin? _____ minutes

11. How often does the headache occur?
    <1/month 1-3/month 1/week 2-3/week >3/ week Daily Always
    Other _____
    a. Over the last three months, how many days PER MONTH did you have a headache? _____
    b. Does the headache change your activity level (ie stop playing)? YES NO
    c. Does activity or playing make the headache worse? YES NO
    d. When you get a headache at school, at what level are you able to function?
       100% 75% 50% 25% 0%
    e. When you get a headache playing at what level are you able to function?
       100% 75% 50% 25% 0%

12. Is there a pattern to the headaches? YES NO
    What pattern? _____

13. Does the headache occur at a particular time of day? YES NO
    Waking up Morning Afternoon Evening Night While asleep

14. Are the headaches associated with a particular season? YES NO
    Which season? _____

15. At what age do you think the headaches began? _____

16. How long have you had headaches? _____

17. Do you think anything caused the headaches to begin? YES NO
    What? _____

18. Have other health care professionals seen you for headaches? YES NO
    Who? _____

19. Have any studies or evaluations been performed? YES NO
    MRI CT/CAT scan Sinus X-ray EEG Other _____

20. Has the *frequency* of the headaches changed? YES NO
    If so, how? _____

21. Has the *severity* of the headaches changed? YES NO
    If so, how? _____

22. Has the *duration* of the headaches changed? YES NO
    If so, how? _____

23. Have the *associated symptoms* changed? YES NO
    If so, how? _____

24. What over-the-counter medications is your child using for his/her headache?
    Acetominophen (Tylenol^{R}) Ibuprofen (Advil^{R}/Motrin^{R}) Excedrin Migraine^{R}
    Aspirin Naproxen (Aleve^{R}) Other _____

25. What other methods do you use to help headaches?
    Sleep Cold compress Hot shower/bath Relaxation Playing/exercise Eating Other _____

26. Has anyone in the past every prescribed a DAILY medication to prevent headaches? YES NO
    Which one(s)? _____

HEADACHE DISABILITY The following questions try to assess how much the headaches are affecting day-to-day activity. Your answers should be based on the last three months. There is no "right" or "wrong" answers so please put down your best guess.

1a. How many full school days were missed in the last 3 months due to headaches? _____

1b. How many partial school days were missed in the last 3 months due to headaches (do not include full days counted in the first question)? _____

2. How many days in the last 3 months did you function at less than half your ability in school because of a headache (do not include days counted in the first two questions)? _____

3. How many days were you not able to do things at home (ie chores, homework, etc.) due to a headache? _____

4. How many days did you not participate in other activities due to headaches (ie play, go out, sports, etc.)? _____

5. How many days did you participate in these activities, but functioned at less than half your ability (do not include days counted in question number 4)? _____

BIRTH and PAST HISTORY:

Mother's PREGNANCY:

Any problems? **YES** **NO**

Mom's previous pregnancies/miscarriages_____Other children_____

DELIVERY: Hospital and City of birth: _____

Any problems? **YES** **NO** _____

Full term or early? _____ How long labor? _____

Breech? _____Forceps? _____C-section? _____

NEWBORN: **Any problems**? **YES** **NO** _____ Birth weight _____

Length _____ How long in hospital? _____ Intensive care? **YES** **NO**

Any other hospitalizations? **YES** **NO** _____

Any surgeries? **YES** **NO** _____

Accidents (especially head trauma)? **YES** **NO** _____

Illnesses (especially infection involving the brain)? **YES** **NO** _____

Other diagnoses? **YES** **NO**

Seizures ADD/ADHD Asthma Strokes Depression

Anxiety Other _____

Recent travel outside this country? **YES** **NO** _____

Exposures to toxic substances? **YES** **NO** _____

EARLY DEVELOPMENT:

Any concerns with early development? **YES** or **NO**

IF SO, then give *approximate* age at which following appeared: Or circle **ALL NORMAL**

Rolled over _____ Sat without support _____

Walked _____ Toilet-trained _____

Single words _____ Talked in 3-word sentences _____

CURRENT SCHOOL

Name of school: _____ Grade: _____

School type:

Public Private Charter Home-schooled College

REGULAR or **SPECIAL** classes?

Any concerns with current school functioning? **YES** or **NO**

Any therapies (PT, ST, OT, tutoring)? _____

Performance in school? _____ Behavior in school? _____

Reading level (if known) _____ Math level (if known) _____

Does your child have any of the following behavior concerns? Circle

Hyperactivity? At home / school Short attention span? At home/ school

Impulsivity? At home / school Poor judgement? At home / school

Moodiness? At home / school Distractibility? At home / school

SOCIAL HISTORY:

Who lives in the home with the child currently? _____

Please note the *biological* parents' status:

Married/living together? _____ Divorced/ separated? _____

If divorced/ separated, do both parents have equal custody? _____

FAMILY HISTORY (biological parents):

Mother's name _____Age: _____ Health_____
Father's name _____Age:_____ Health_____
Brother(s) name _____Age: _____ Health_____
Sister(s) name _____Age: _____ Health_____
WHO in the family (if anyone) has similar headaches to the child? _____

If there is a **family history** of any of the following, please note:

Headaches/Migraines	Deafness	Depression
Diabetes	Cancer	Drug abuse/ Alcoholism
Seizures/ epilepsy	TB	Intellectual disability or Learning disability
Heart disease	Hypertension	Brain tumor
Thyroid	Neuromuscular or other neurological disease	

		HEADACHES (Any type)	MIGRAINES	TENSION HEADACHE	SINUS HEADACHE	Other medical or mental health concerns
FATHER						
MOTHER						
Siblings	Age					
BROTHER						
SISTER						

		HEADACHES (Any type)	MIGRAINES	TENSION HEADACHE	SINUS HEADACHE	Other medical or mental health concerns
Dad's Father						
Dad's Mother						
Mom's Father						
Mom's Mother						
Aunts and Uncles	#					
DAD's brothers						
DAD's sisters						
MOM's brothers						
MOM's sisters						
Other _____						

REVIEW OF SYSTEMS:

PHOENIX CHILDREN'S *Medical Group*®

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If your child has any of the following concerns, please note if it is a problem *NOW* or in the *PAST:*

General: Excessive fatigue? _____ Other _____

Eyes: Blurred vision _____Squinting _____ Double vision _____
Blind spots _____ Loss of vision _____ Crossed eyes _____
Odd eye movements _____ Recent eye examination? _____

ENT: Ringing in ears _____ Hearing problems _____ Ear infections _____
Draining ears _____ Allergies _____ Other _____

Heart: Fainting _____ History of murmur? _____ Dizziness with exercise? ____ Other _____

Lungs: Asthma _____ Wheezing _____ Pneumonia _____
Choking/coughing _____ Other _____

Musculoskeletal: RIGHT or LEFT handed? Clumsiness _____ Fractures _____
Muscle weakness _____ Limping _____ Stumbling/ excessive falling ____
Bone pain ____ Abnormality or deformity of bones or joints _____ Scoliosis _____ Other ____

Gastrointestinal: Nausea _____ Vomiting _____ Diarrhea _____
Constipation _____Blood in stools/ black stools _____ Other _____
>> Do you think your child's *food choices* or *diet* contribute to the headaches? _____

Genitourinary: Bladder or kidney infections? _____ Blood in urine _____
Painful or frequent urination _____ Other _____

Skin: Rashes _____ Birth marks _____ Eczema _____ Other _____

Sleep problems: Sleeplessness _____ Teeth grinding _____
Restless sleeping _____ Excessive daytime sleepiness _____
Bed wetting _____ Night terrors/nightmares _____
Sleepwalking _____ Snoring _____ Other _____
>>Do you think that your child's headaches interfere with sleep? _____
>>Do you think that *too little sleep* or *too much sleep* brings on your child's headaches? _____

Neurological: Dizziness _____ Lightheadedness _____ Jerks _____
Abnormal movements _____ Speech problems _____
Trouble writing _____ Trouble thinking _____
Loss of any previously acquired developmental functions? _____
Convulsions _____ Seizures _____ Staring spells _____
Prior head injury with or without loss of consciousness _____ Other _____

Psychiatric: Severe mood swings _____ Severe behavioral problems ____
Depression (current or previous) _____ Prior trauma or abuse _____
History of seeing a psychologist/psychiatrist? _____ Other _____

Heme/Lymph: Anemia _____ Swollen lymph nodes _____ Other _____

Endocrine: Thyroid problems? _____ Early onset of puberty (boys or girls) _____
Excessive sweating _____ Excessive thirst and urination _____
Excessive hunger _____ Always too cold or too hot _____ Other _____
GIRLS: at what age was the first period? _____ Are they regular? YES NO NOT SURE
Are your headaches WORSE with your periods? YES NO NOT SURE N/A
If you haven't had a period OR they just started, do you have monthly headaches? YES NO NOT SURE
____days Severity ____ Duration _____

ANY OTHER CONCERNS NOT ADDRESSED ELSEWHERE?

_____

_____

_____

_____ _____

Signature of Patient/Legally Authorized Representative **Relationship to Patient**

_____ _____

Printed Name of Patient/Legally Authorized Representative **Date & Time**

_____ _____

Practitioner Signature **Date & Time**

_____

Practitioner Printed Name