HEADACHE HISTORY

Specific Headache Location _____ _____ **(initial if NO HA, ever)**

Is the headache every day? ❑ No ❑ Yes | Frequency: (number) ____per day ____per week ____per month

LOCATIONS: ❑ Both temples ❑ Side head ❑ Back of head ❑ Behind eyes ❑ Whole head

Date **1st headache** -_____ | **Date 1st Treatment:**_____ | **Right**:____ **Left** ____

Is there a warning before headache? Visual _____ ❑ No ❑ Yes Describe:_____

Is headache associated with event, condition, or circumstance? ❑ No ❑ Yes _____

Type of pain: (*check all that apply*) ❑ Dull ❑ Ache ❑ Deep ❑ Superficial ❑ Burning ❑ Sharp
❑ Shooting ❑ Tingling ❑ Throbbing ❑ Crawling ❑ Other: _____

Duration headache: (*enter a number in blank*): _____ seconds _____ minutes _____ hours _____ days

Worst pain: (*circle **ONE** number*)	No pain	0	1	2	3	4	5	6	7	8	9	10 most pain
Least pain: (*circle **ONE** number*) Circle 0 if not constant headache		0	1	2	3	4	5	6	7	8	9	10
Average pain: (*circle **ONE** number*)		0	1	2	3	4	5	6	7	8	9	10

My headaches are: ❑ comes goes ❑ continuous | Speed of onset: ❑ Gradual ❑ Abrupt

IS the pain: ❑ Same ❑ Better ❑ Worse If worse, increased: ❑ Frequency ❑ Severity ❑ Duration

Worst time of day: (*check **one***) ❑ Awakening ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ Sleeping

Worse on workdays? ❑ Yes ❑ No | Is HA affected by stress? ❑ Yes ❑ No

Can HA Interrupt sleep? ❑ Yes ❑ No | Family members w/ same headache? ❑ Yes ❑ No

What makes this headache worse?

What makes this headache better?

What is this headache's pattern?

Describe Post Headache symptoms: light sensitivity, imbalance, sound sensitivity, nausea, vomit:_____

If HA became constant, date: _____, explain: _____

List all medications HA:_____**, help (+), no benefit (-)**
List all treatments HA:_____**, benefit (+), no benefit (-)**
List all family members w/ HA: _____

JAW JOINT NOISE

Describe when the noise began, how & when it changed, and current TMJ noises.

Specific joint click occurred: ❑ Rt ❑ Lt | Tell about 1st time- remember hearing? _____ _____

Year click or pop 1st noticed _____ _____ | Did sound change? Click to pop to gravel ❑ Yes ❑ No

No TMJ Noise	**Initial Onset**		**Progression-Change**		**Current Noise**	
_____ (initial)	**Month & Year: _____/_____**		**Month & Year: _____/_____**		**Month & Year: _____/_____**	
	Sound	**No pain**	**Sound**	**Pain?**	**Sound**	**Pain?**
Right Only	❑ Pop ❑ Click	❑	❑ Pop ❑ Click	❑ Yes	❑ gravel ❑ Click	❑ Yes
Left Only	❑ Pop ❑ Click	❑	❑ Pop ❑ Click	❑ Yes	❑ gravel ❑ Click	❑ Yes
Both TMJ's	❑ Pop ❑ Click	❑	❑ Pop ❑ Click	❑ Yes	❑ gravel ❑ Click	❑ Yes
Frequency	❑ Intermittent ❑ frequent ❑ On all open _____		❑ Intermittent ❑ most of time ❑ on all open _____		❑Intermittent ❑ most time ❑ on all open _____	
Loudness	❑ Only by me ❑ Others nearby ❑ Across room		❑ Only by me ❑ Others nearby ❑ Across room		❑ Only by me ❑ Others nearby ❑ Across room	

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