

HEADACHE QUESTIONNAIRE

Form NTIQ1

This questionnaire was designed to provide important facts regarding the history of your condition. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible. Please sign each page.

Patient Information

TODAY'S DATE: _____

MR. MS MISS NAME: _____

MRS. DR. FIRST MIDDLE INITIAL LAST

AGE: _____ DATE OF BIRTH: _____ Male Female

ADDRESS: _____

CITY/STATE/ZIP: _____

HOW LONG AT CURRENT ADDRESS? _____ (IF LESS THAN THREE YEARS, PLEASE GIVE PREVIOUS ADDRESS)

PREVIOUS ADDRESS: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE _____ EMAIL: _____

RESPONSIBLE PARTY: _____

FAMILY PHYSICIAN _____

ADDRESS _____

REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please number the complaints with #1 being the most important.

___ Headaches Other: _____

___ Facial pain _____

___ Jaw clenching at night _____

Sensations I experience with headaches:

- Nausea Fatigue (he/she must lie down during these episodes)
 Light sensitivity Dizziness
 Noise sensitivity Blurred vision

HISTORY OF PRESENT ILLNESS

Have you been medically diagnosed with (check all that apply): Migraine Headaches Tension Headaches

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN




KEY: L= Left R=Right B=Both sides

		SEVERITY			FREQUENCY			DURATION					
		MILD	MODERATE	SEVERE	OCCASIONAL	FREQUENT	CONSTANT	SECONDS	MINUTES	HOURS	DAYS	WEEKS	
<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Front of your head (Frontal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Entire head (Generalized)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Back of your head (Occipital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	In your temples (Temporal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

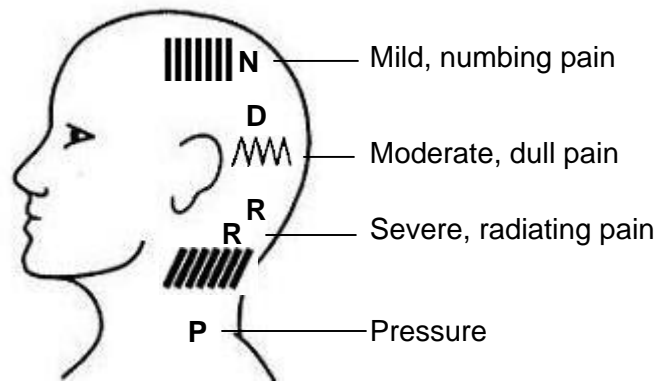
I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____

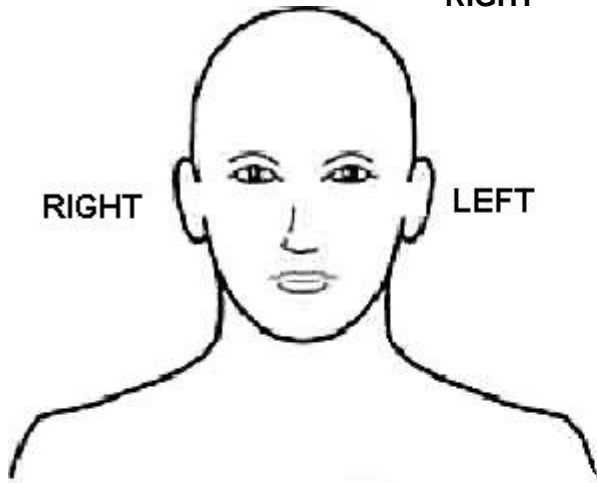
DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN		B Burning
		D Dull
		N Numbing
MODERATE PAIN		P Pressure
		S Sharp
SEVERE PAIN		T Tingling
		R Radiating

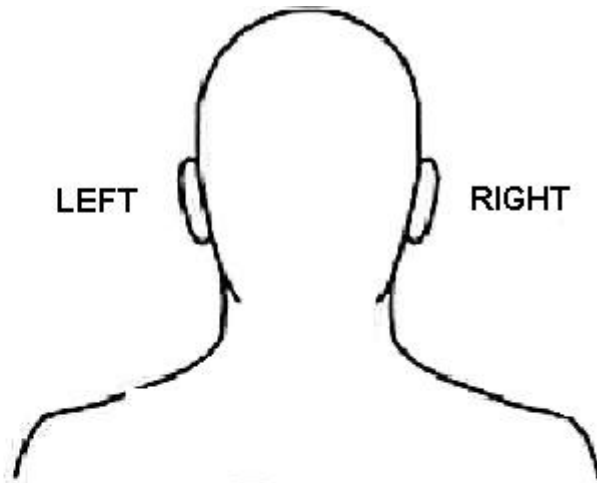
EXAMPLE



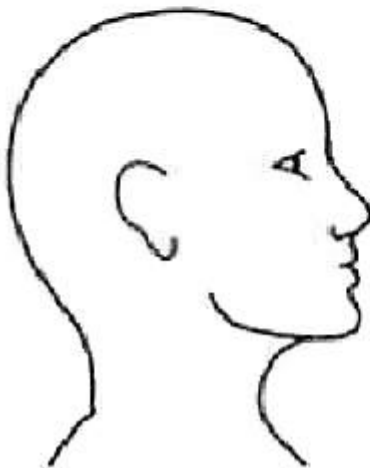
RIGHT



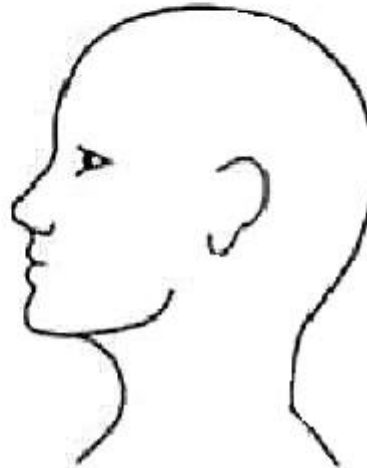
LEFT



RIGHT



LEFT



Patient Signature _____

Date _____

List any medications which have caused an allergic reaction:

- | | | |
|---|--|------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Antibiotics | <input type="checkbox"/> Y <input type="checkbox"/> N Metals | Other allergens: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates | <input type="checkbox"/> Y <input type="checkbox"/> N Plastic | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Sedatives | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Iodine | <input type="checkbox"/> Y <input type="checkbox"/> N Sleeping pills | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfa drugs | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Local anesthetics | | |

List any medications you are currently taking:

- | | | |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Antacids | <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Pain medication |
| <input type="checkbox"/> Y <input type="checkbox"/> N Antibiotics | <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone | <input type="checkbox"/> Y <input type="checkbox"/> N Sleeping pills |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anticoagulants | <input type="checkbox"/> Y <input type="checkbox"/> N Diet pills | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfa drugs |
| <input type="checkbox"/> Y <input type="checkbox"/> N Antidepressants | <input type="checkbox"/> Y <input type="checkbox"/> N Heart medication | <input type="checkbox"/> Y <input type="checkbox"/> N Tranquilizers |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anti-inflammatory drugs (non-steroid) | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure medication | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates | <input type="checkbox"/> Y <input type="checkbox"/> N Insulin | Other current medications: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood thinners | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle relaxants | _____ |
| | <input type="checkbox"/> Y <input type="checkbox"/> N Nerve pills | _____ |

Medical History

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Heart pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoarthritis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis | <input type="checkbox"/> Y <input type="checkbox"/> N Heart valve replacement | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Heartburn or a sour taste in the mouth at night | <input type="checkbox"/> Y <input type="checkbox"/> N Poor circulation |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune disorders | | <input type="checkbox"/> Y <input type="checkbox"/> N Prior orthodontic treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding easily | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Recent excessive weight gain |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic sinus problems | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic fatigue | <input type="checkbox"/> Y <input type="checkbox"/> N Immune system disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congestive heart failure | <input type="checkbox"/> Y <input type="checkbox"/> N Injury to | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Current pregnancy | <input type="checkbox"/> <input type="checkbox"/> Face <input type="checkbox"/> Neck | <input type="checkbox"/> Y <input type="checkbox"/> N Swollen, stiff or painful joints |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> <input type="checkbox"/> Head <input type="checkbox"/> Mouth <input type="checkbox"/> Teeth | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty concentrating | <input type="checkbox"/> Y <input type="checkbox"/> N Insomnia | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> N Irregular heart beat | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillectomy (have had) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw joint surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Wisdom teeth extraction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Low blood pressure | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fibromyalgia | <input type="checkbox"/> Y <input type="checkbox"/> N Memory loss | Other medical history: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent sore throats | <input type="checkbox"/> Y <input type="checkbox"/> N Migraines | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Gastroesophageal Reflux Disease (GERD) | <input type="checkbox"/> Y <input type="checkbox"/> N Morning dry mouth | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay fever | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle spasms or cramps | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Needing extra pillows to help breathing at night | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart pounding or beating irregularly during the night | <input type="checkbox"/> Y <input type="checkbox"/> N Nighttime sweating | |

Patient Signature _____

Date _____