

PITTSBURGH MIGRAINE CHALLENGE

Name: _____ Date of Birth: _____ Gender: Male Female

Home Address: _____
Street City State Zip

Home: () _____ Cell: () _____

Email: _____

How long have you suffered from headaches or migraines? _____

Frequency: _____ Intensity: _____

Location: (circle all that apply) Global Sub-Occipital Temporal: Left Right Bilateral
Frontal Facial Eyes: Left Right Bilateral Other: _____

Symptoms: (circle all that apply) Nausea Vomiting Light Sensitive Sound Sensitive Auras

Others: _____

Known Triggers: Please List _____

Current forms of Treatment: (if medicinal please list name and amount) _____

Ineffective forms of Treatment: _____

Have you ever visited a Chiropractor in regards to your headaches/Migraines? What were the results?

How would your life be different if you never suffered from another migraine? (Please list your top 3):

1. _____
2. _____
3. _____

What are the top 3 things that migraines prevent you from doing?

4. _____
5. _____
6. _____

Which relationships are most effected by your migraines?

1. _____
2. _____
3. _____

Please list any other information regarding your migraines that you would like the doctors to know:



Headache Disability Index

Date _____

Patient Name: _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off “YES”, “SOMETIMES”, or “NO” to each item. Answer each question as it pertains to your headache only.

YES SOMETIMES NO

- | | | | |
|-------|-------|-------|--|
| _____ | _____ | _____ | Because of my headaches I feel disabled. |
| _____ | _____ | _____ | Because of my headaches I feel restricted in performing my routine daily activities. |
| _____ | _____ | _____ | No one understands the effect my headaches have on my life. |
| _____ | _____ | _____ | I restrict my recreational activities (eg, sports, hobbies) because of my headaches. |
| _____ | _____ | _____ | My headaches make me angry. |
| _____ | _____ | _____ | Sometimes I feel that I am going to lose control because of my headaches. |
| _____ | _____ | _____ | Because of my headaches I am less likely to socialize. |
| _____ | _____ | _____ | My spouse (significant other), or family and friends have no idea what I am going through because of my headaches. |
| _____ | _____ | _____ | My headaches are so bad that I feel that I am going to go insane. |
| _____ | _____ | _____ | My outlook on the world is affected by my headaches. |
| _____ | _____ | _____ | I am afraid to go outside when I feel that a headaches is starting. |
| _____ | _____ | _____ | I feel desperate because of my headaches. |
| _____ | _____ | _____ | I am concerned that I am paying penalties at work or at home because of my headaches. |
| _____ | _____ | _____ | My headaches place stress on my relationships with family or friends. |
| _____ | _____ | _____ | I avoid being around people when I have a headache. |
| _____ | _____ | _____ | I believe my headaches are making it difficult for me to achieve my goals in life. |
| _____ | _____ | _____ | I am unable to think clearly because of my headaches. |
| _____ | _____ | _____ | I get tense (eg, muscle tension) because of my headaches. |
| _____ | _____ | _____ | I do not enjoy social gatherings because of my headaches. |
| _____ | _____ | _____ | I feel irritable because of my headaches. |
| _____ | _____ | _____ | I avoid traveling because of my headaches. |
| _____ | _____ | _____ | My headaches make me feel confused. |
| _____ | _____ | _____ | My headaches make me feel frustrated. |
| _____ | _____ | _____ | I find it difficult to read because of my headaches. |
| _____ | _____ | _____ | I find it difficult to focus my attention away from my headaches and on other things. |

I understand that the information I have provided above is current and complete to the best of my knowledge.

Patient's Signature: _____ Date: _____

NEW PATIENT APPLICATION

PATIENT INFORMATION

Patient Name _____
LAST NAME

FIRST NAME MIDDLE INITIAL

Address _____

City _____ State _____

Home Phone _____

Cell Phone _____

Email _____

Sex M F Age _____ Birthday _____

Married Widowed Single Minor

Separated Divorced Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

If you are already experiencing a symptom, what is it? _____

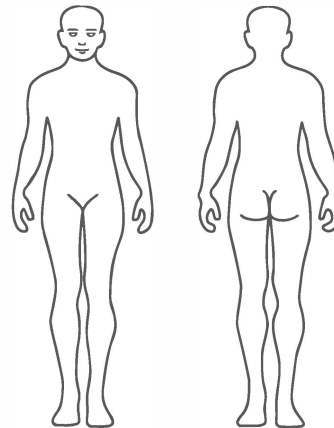
How bad is it? How intense are your symptoms? (circle) **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

NO SYMPTOMS INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:

What does it feel like? (check where appropriate)

- Numbness
- Sharp
- Tingling
- Shooting
- Stiffness
- Burning
- Dull
- Throbbing
- Aching
- Stabbing
- Cramping
- Swelling
- Nagging
- Other _____



IMPACT OF YOUR SYMPTOMS

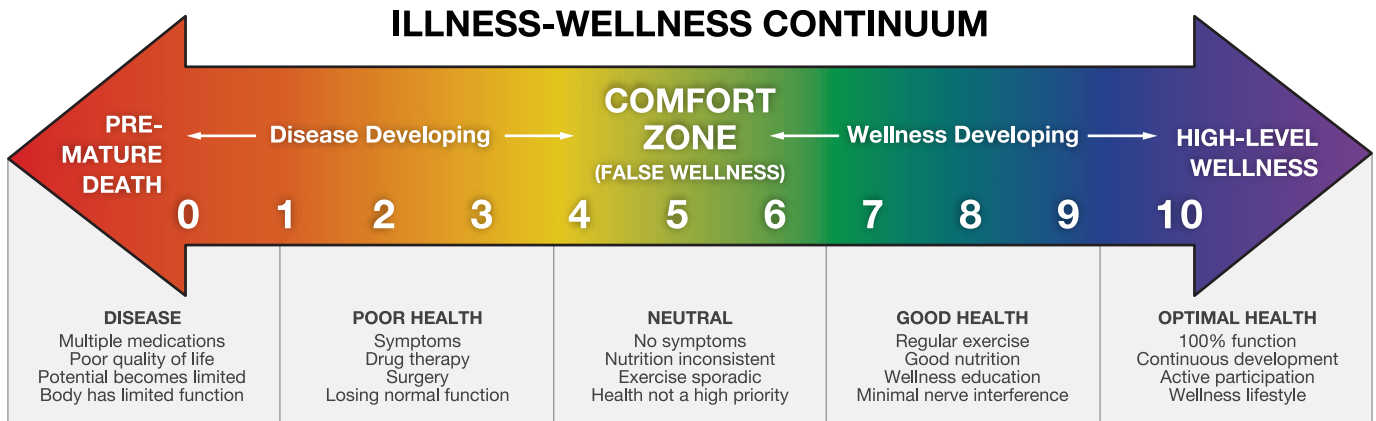
How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue? **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

NOT COMMITTED VERY COMMITTED

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? No Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Circulation Issues | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Childhood Illness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shoulder Issues |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hip Issues | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Issues
(Constipation/Diarrhea/GERD/IBS) | <input type="checkbox"/> Immune Issues | <input type="checkbox"/> TMJ Issues |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Elbow/Wrist/Hand Issues | <input type="checkbox"/> Lymphatic Issues | <input type="checkbox"/> Urinary Issues |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Endocrine Issues (Thyroid) | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> Foot/Ankle Issues | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Reproductive Issues | _____ |

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

MEDICATIONS (list)

SUPPLEMENTS (list)

