Department of Neurology
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

uchealth

Welcome! Thank you for choosing the Headache Clinic at University of Colorado Hospital for your health care needs. Targeting the best outcomes for patients, our providers bring together top expertise and state-of-the art resources to identify and treat underlying causes of your symptoms. We are strongly committed to an active partnership with you to achieve the optimal care. Please see this overview of expectations to make the most of your experience at UCHealth.

Come prepared:

- Complete the attached 4 page New Patient Headache Questionnaire and bring it to the initial visit.
- Headache diaries are helpful, for example: www.migrainebuddy.com; www.curelator.com; www.bontriage.com http://hortonmoise.com/wp-content/uploads/2016/10/Monthly_Headache_Diary.pdf
- Send or bring in referral, clinical notes, imaging tests (i.e. MRIs, CTs) prior to your appointment. Fax 720-848-2106.
- Know the medications you take, check with your pharmacy if necessary.
- Check with your insurance for any necessary authorizations.

What you can expect:

- Comprehensive diagnostic evaluation by neurologists specializing in Headache and Pain
- Comprehensive management plan including:
  - Non-pharmacologic: i.e. relaxation, trigger management, exercise, sleep, and diet recommendations.
  - Pharmacologic therapies: preventative and abortive medications - avoid misuse.
  - Procedures: Botox injections for chronic migraine, nerve blocks, trigger point injections, other.
  - Referrals to Integrative Medicine, Outpatient Infusion Center, Pain Clinic, Physical Therapy, Psychology and other specialties as well as inpatient treatment, as appropriate.
- Follow up and procedures with physicians or nurse practitioners with expertise in Headache and Pain solutions for up to one year at which time we will re-evaluate for further management of symptoms.
- Opportunities to participate in clinical trials to advance research in the area of headache and migraine care.

The clinic/patient relationship: we encourage you to stay connected with your specific life goals that are defined by your own values and needs, and not by headache pain. To assist us in helping you, **please be an active participant** in your care.

- Read and follow instructions on your After Visit Summary provided at check-out.
- Sign up for the patient portal, My Health Connection, at www.uchealth.org
- Be respectful to all clinic staff members.
- Address clinical care questions with your care providers by phone at 720-848-2080 or via My Health Connection. All questions are taken seriously and will be triaged and answered professionally. Please allow appropriate time for answering symptom calls (24-48 hours) and non-urgent questions (24-72 hours). As always, in the event of a life-threatening situation call 911.

Thank you, again, for allowing us to participate in your health care. We look forward to working with you!

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Jeff Reynek, NP Jessica Scharein, DNP Whitney Tice, NP

New Patient Headache Questionnaire

Name: _____ Primary Care Provider _____

1. When did your headaches **start**? #_____days ago // # _____weeks ago // # ___months ago// # ___years ago

2. Did your headache start after a **head injury**? ◯ No ◯ Yes -describe _____

3. Did your headache start after an **infection or other medical condition**? ◯ No ◯ Yes-what? _____

4. Did your headache begin when you started or changed a **medication**? ◯ No ◯ Yes -which one? _____

5. Has your headache **changed in course/pattern**? ◯ No ◯ Yes- when? _____

6. **How many days in a month do you have a headache**? _____How many headache-free days/month?_____

7. How long do your headaches **last**? Shortest _____Longest _____Average _____// OR Constant? ◯ Yes ◯ No

8. Your headaches are **worse** in the: ◯ morning ◯ afternoon ◯ evening ◯ during the night ◯ no pattern

9. How **severe** is your headache (from 0 - *no pain at all* to 10 - *worst possible pain*)? Average _____Worst _____

10. Where are your headaches usually **located**?

◯ Temple [R L both]
◯ Back of the head [R L both]
◯ Side of the head [R L both]
◯ Front of the head [R L both]
◯ Whole head
◯ Ear [R L both]
◯ Eye [R L both]
◯ Neck
◯ Face [R L both]
◯ Other _____
◯ Changing location _____

11. Your headaches usually **feel like**:

◯ Throbbing/Pulsating
◯ Achy
◯ Tight
◯ Dull
◯ Stabbing
◯ Pressure
◯ Shooting
◯ Burning
◯ Other_____

12. **Provoking Factors** (triggers, things that bring on a headache)

Environmental: ◯ Weather changes ◯ Altitude ◯ Sunlight ◯ Allergies ◯ Other: _____

Food/beverage: ◯ Skipping meals ◯ Caffeine ◯ Processed meet ◯ MSG ◯ Aged cheese ◯ Chocolate

◯ Alcohol beverages:- Wine: [Red White] ◯ Other:_____

Hormonal: Menses: ◯ Before ◯ During ◯ Late cycle // ◯ Pregnancy // ◯ Menopause _____

Physical activity/exertion: ◯ Bending over ◯ Exercise ◯ Sexual intercourse ◯ Coughing ◯ Other_____

Sleep: ◯ Lack of sleep ◯ Too much sleep ◯ Change in wake/sleep _____

Stress: ◯ Work ◯ Home ◯ Family ◯ Spouse ◯ Other: _____

Other Triggers: _____

13. **Premonitory symptoms** (you experience one or more of these symptoms 1 to 2 days before the onset of headache)

◯ Hyperactive
◯ Depressed feeling
◯ Irritability
◯ Feeling sluggish
◯ Dizziness
◯ Difficulty concentrating
◯ Sensitive to light
◯ Sensitive to sound/noise
◯ Difficulty with speech
◯ Excessive yawning
◯ Food cravings
◯ Increased appetite
◯ Decreased appetite
◯ Increased urination
◯ Neck pain/stiffness
◯ Other _____

14. **Aura**: ◯ No ◯ Yes- If you have any of the **symptoms below**, they usually last: _____ minutes and occur about:

◯ _____minutes before pain starts ◯ during the head pain ◯ after the head pain; ◯ without the head pain

Visual

◯ Blurry vision
◯ Flashing lights
◯ Zigzag lines
◯ Spots [bright dark]
◯ Loss of vision on one side
◯ Total blindness
◯ Tunnel vision
◯ Wavy lines
◯ Double vision
◯ Other _____

Sensory and other:

◯ Numbness/tingling [R L Both]
◯ One-sided weakness [R L Both]
◯ Speech difficulty
◯ Vertigo/unsteadiness
◯ Confusion
◯ Smell changes
◯ Other_____

15. Do you have **associated symptoms during your headache**? (mark all that apply)

◯ Nausea or upset stomach/vomiting
◯ Sensitivity to light (prefer a dark room)
◯ Sensitivity to sound (prefer a quiet room)
◯ Sore/stiff neck
◯ Vision changes (blurred, spots, patterns)
◯ Confusion
◯ Difficulty thinking/concentrating/focus
◯ Difficulty speaking/slurred speech
◯ Insomnia
◯ Sleepiness
◯ Irritability
◯ Anxiety
◯ Memory problems
◯ Imbalance
◯ Dizziness/vertigo/lightheadedness
◯ Restlessness
◯ Eye tearing in only one eye [R L]
◯ Runny nose in only one nostril [R L]
◯ Eye-redness in only one eye [R L Both]
◯ Drooping eyelid only one side [R L Both]
◯ Swelling of eyelid only one side [R L Both]
◯ Change in pupil only one side [Larger Smaller]
◯ Ringing in the ears
◯ Sensitivity to smells
◯ Decreased appetite
◯ Increased appetite
◯ Constipation
◯ Diarrhea
◯ Increased Urination
◯ Numbness/Tingling [R L Both] face, arm, leg? _____
◯ Weakness [R L Both] face, arm, leg?_____
◯ Other_____

16. **Headache relieving measures**:

◯ Lying down
◯ Dark quiet room
◯ Massage
◯ Standing
◯ Ice/Cold compress
◯ Hot compress
◯ Keeping active/pacing
◯ Other_____

17. Which **Acute/abortive** medications (medications taken to **stop** a headache) have you used?

Acute/abortive medication	On average, how many days per week?	Helping? (YES/NO)
Acetaminophen *(Tylenol)*		
Almotriptan *(Axert)*		
Aspirin		
Baclofen *(Lioresal)*		
Celecoxib *(Celebrex)*		
Cyclobenzaprine *(Flexeril)*		
Diclofenac *(Cambia)*		
Dihydroergotamine *(Migranal, DHE)*		
Diphenhydramine *(Benadryl)*		
Eletriptan *(Relpax)*		
Excedrin		
Fioricet, Fiorinal		
Frovatriptan *(Frova)*		
Ibuprofen *(Advil/Motrin)*		
Indomethacin *(Indocin)*		
Ketorolac *(Toradol)*		
Lidocaine nasal spray		
Metaxalone *(Skelaxin)*		
Metoclopramide *(Reglan)*		
Midrin *(Duradrin, Epidrin)*		
Naproxen *(Naprosyn, Aleve)*		
Naratriptan *(Amerge)*		
Ondansetron *(Zofran)*		
Prochlorperazine *(Compazine)*		
Promethazine *(Phenergan)*		
Rizatriptan *(Maxalt)*		
Sumatriptan *(Imitrex)*		
Tizanidine *(Zanaflex)*		
Tramadol *(Ultram)*		
Vicodin, Codeine, Demerol, Percocet		
Zolmitriptan *(Zomig)*		
Other:		

18. **Procedures** tried (check all that apply): Helped? Yes/No

Occipital nerve blocks: ◯ R ◯ L ◯ Both _____
Auriculotemporal nerve blocks: ◯ R ◯ L ◯ Both _____
Supra-orbital/Supra-trochlear nerve block: ◯ R ◯ L ◯ Both _____
Trigger point injections _____
Head/Neck injections under X-ray guidance: ◯ Yes ◯ No _____
Botox injections: _____
Other _____

19. **Behavioral** treatments and **supplements**

Behavioral/Physical therapy	Helping? (yes/no)	Supplements	Helping? (yes/no)
Psychologist, therapist		B2 Vitamin (Riboflavin)	
Physical therapy		Co-enzyme Q10	
Yoga		Magnesium	
Chiropractic therapy		Marijuana	
Acupressure/acupuncture		Melatonin	
Biofeedback		Petadolex (Butterbur)	
Other		Other	

20. Which **Preventive** medications or devices (taken daily/regularly to prevent headaches) have you tried?

Preventive medication	How long did you take it for? Weeks/Months/Years
Amitriptyline *(Elavil)*	
Botox injections *(Onabot. Tox. A)*	
Candesartan *(Atacand)*	
Gabapentin *(Neurontin)*	
Lamotrigine *(Lamictal)*	
Lisinopril *(Zestril)*	
Metoprolol *(Lopressor)*	
Methylergonovine *(Methergine)*	
Nortriptyline *(Pamelor)*	
Pregabalin *(Lyrica)*	
Propranolol *(Inderal)*	
Topiramate *(Topamax)*	
Valproic Acid *(Depakote)*	
Venlafaxine *(Effexor)*	
Verapamil *(Calan)*	
Zonisamide *(Zonegran)*	
Other medication	
Cefaly, TMS or other device	

21. Have you needed to go to the **emergency room** (ED) for headaches? ◯ Yes ◯ No; If yes, how often? _____

What makes/made you decide to go to ED?	Yes/No	Comment
Lack of acute/abortive medications at home		
Lack of pain relief with home medications		
Nausea/vomiting		
Fear of some dangerous condition		
Lack of outpatient primary care or headache care provider		
Worsening or new headache		
Other symptoms associated with headache		
Other		