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:

____

____

____

____

____

____

HELPING YOU GET YOUR LIFE BACK!

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: ______________________

CHIROPRACTIC INTAKE & HISTORY

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

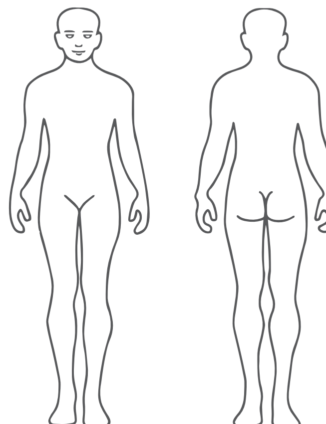
Name ____________________
Relationship ____________________
Contact Number ____________________
Who may we thank for referring you? ____________________

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 ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿
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 ____________

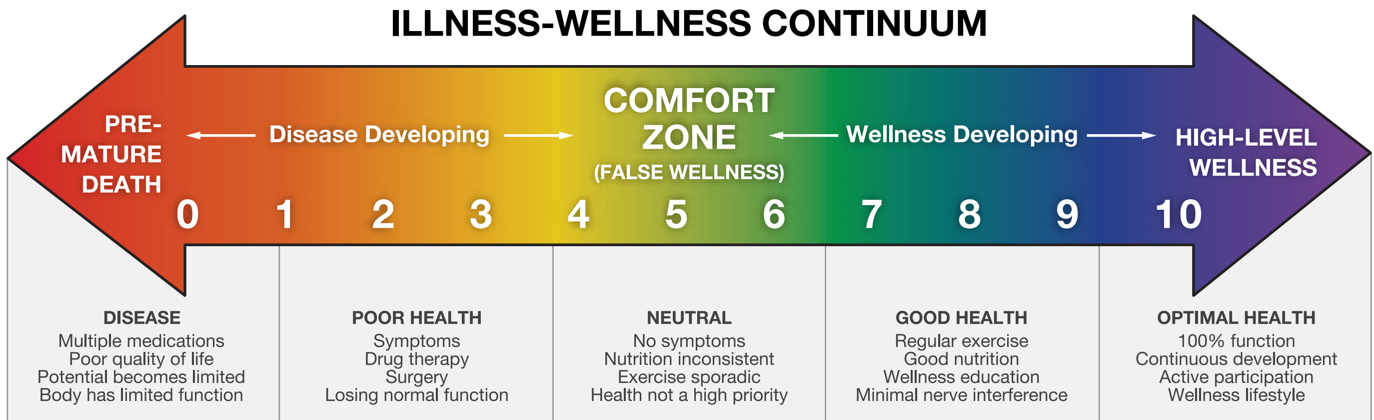
IMPACT OF YOUR SYMPTOMS

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	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other ________	❑	❑	❑	❑

How committed are you to correcting this issue? ⓪ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿
NOT COMMITTED — VERY COMMITTED

PATIENT WELLNESS ASSESSMENT



DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

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.

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

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

____

____

____

MEDICATIONS (list)

____

____

____

SUPPLEMENTS (list)

____

____

____