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:(Select all that apply) ☐ Global ☐ Sub-Occipital Temporal: ☐ Left ☐ Right ☐ Bilateral

☐ Frontal ☐ Facial Eyes: ☐ Left ☐ Right ☐ Bilateral Other: _____

Symptoms:(Select 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!