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? _____

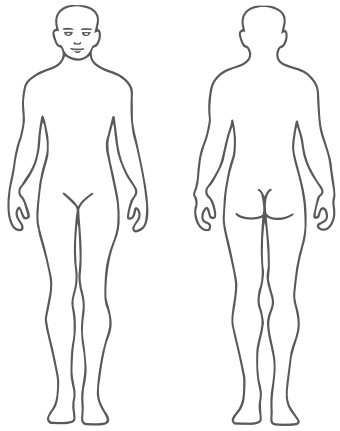
_____

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

How bad is it? How intense are your symptoms? (circle)

0 NO SYMPTOMS 1 2 3 4 5 6 7 8 9 10 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 NOT COMMITTED 1 2 3 4 5 6 7 8 9 10 VERY COMMITTED

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

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)
_____	_____	_____
_____	_____	_____
_____	_____	_____