Name:_____ Date_____

Headache & Migraine - Part 1a

Primary Complaint

Instructions: There are seven (7) pages of 'Fill-In' pdf forms. Please provide as much information as possible - this is your opportunity to tell me what has been occurring in the past, your current condition as well as concerns you have for fu- your future should this condition continue.

Indicate all abnormalities or exacerbated conditions that occur simultaneously with your Primary Complaint:

☐ Balance	☐ Appetite	☐ Blood pressure	☐ Energy	☐ Addiction	☐ Fertility
☐ Hearing	☐ Defecation	☐ Arrythmias	☐ Libido	☐ Attitude change	☐ Pain (physical)
☐ Smell	☐ Digestion	☐ Angina	☐ Menses	☐ Behavior change	☐ Twitching-Tics
☐ Speech	☐ Thirst	☐ Breathing	☐ Vaginal fluids	☐ Cravings	☐ Hiccups
☐ Swallowing	☐ Urination	☐ Skin	☐ Semen flow	☐ Emotions	☐ Self Esteem
☐ Taste	☐ Bleeding	☐ Hair	☐ Sleep	☐ Mental function	☐ Self Image
☐ Touch	☐ Mucus flow	☐ Nails	☐ Excess naps	☐ Memory	☐ Motivation
☐ Vision	☐ Swelling			☐ Pain (from emotions)	

Is this your first time seeking treatment for the primary complaint? ☐ Yes ☐ No, I have sought _____ prior.
No. of times

When did the primary complaint become disruptive to your ADL, caused significant impairment or prompted treatment?

_____
How many days, weeks, months or years ago or the date.

When did the primary complaint or associated symptoms begin before the condition became disruptive to your Activities of Daily Living or caused significant impairment?

_____
Indicate the number of days, weeks, months or years or the date.

How frequently does the primary complaint or associated symptoms interfere with Activities of Daily Living?

_____
Indicate number of minutes, hours in a day or number of days/weeks

What do you think is the origin or cause of the primary complaint? _____

_____

What provides relief to the primary complaint? _____

_____

_____

_____

Please answer the following:

Does a sibling have these headaches?	☐ No	☐ Yes	☐ Unknown
Does a parent have these headaches?	☐ No	☐ Yes	☐ Unknown
Are you willing to have blood tests?	☐ No	☐ Yes	☐ Unknown
Are you lactose intolerant?	☐ No	☐ Yes	☐ Unknown
Are you gluteomorphin reactive?	☐ No	☐ Yes	☐ Unknown
Are you caseomorphin reactive?	☐ No	☐ Yes	☐ Unknown

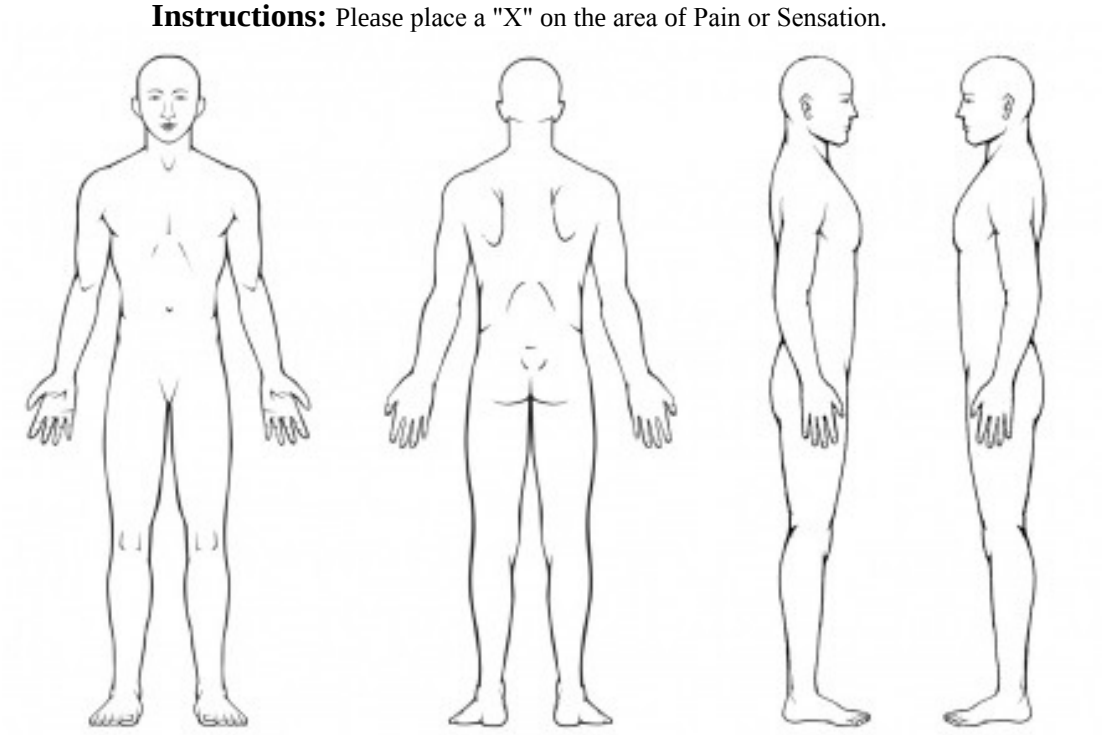
If you need to include more information, write it in a MSWord documents and title it with your name and Primary Complaint. Example: John_Doe_Headache Migraine Part 1a

Name:_____ Date_____

Headache & Migraine - Part 1b

Primary Complaint

Instructions: Please place a "X" on the area of Pain or Sensation.



Front Rear Right Left

Type of Pain or Sensation:

- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing
- ☐ Burning
- ☐ Dull
- ☐ Aching
- ☐ Tingling
- ☐ Numbness
- ☐ Cramping
- ☐ Tightening
- ☐ Stiffness
- ☐ Swelling
- ☐ Heat
- ☐ Cold
- ☐ Crawling
- ☐ Itching

Quality.of Primary Complaint:

- ☐ Constant ☐ Fixed
- ☐ Intermittent ☐ Moving

Trigger or Aggrivated by:

- ☐ Cold ☐ Heat
- ☐ Physical activity
- ☐ Emotional upset
- ☐ Stress ☐ Weather

Rate your pain at it's most and least painfulness:

- ☐ 0 None
- ☐ 1 Mild - nagging, annoying, interferes little with ADLs
- ☐ 2 Mild - nagging, annoying, interferes little with ADLs
- ☐ 3 Mild - nagging, annoying, interferes little with ADLs
- ☐ 4 Moderate - Interfere's significantly with ADLs
- ☐ 5 Moderate - Interfere's significantly with ADLs & need OTC med
- ☐ 6 Moderate - Interfere's significantly with ADLs & need OTC med
- ☐ 7 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 8 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 9 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 10 Severe - Disabling, unable to perform ADLs & Need hospital

Are you hands or feet too sensitive to touch? ☐ Yes ☐ No
Does it hurt at night when bed covers touch? ☐ Yes ☐ No
Do your symptoms worsen at night? ☐ Yes ☐ No
Do your legs feel weak when you walk? ☐ Yes ☐ No
Do your legs/feet hurt when you walk? ☐ Yes ☐ No
Are your feet skin dry and crack open? ☐ Yes ☐ No
Can your feet discern hot/cold water in tub/shower? ☐ Yes ☐ No
Do your legs/feet experience 'asleep feeling' or loss of sensation? ☐ Yes ☐ No
Are you unable to sense you feet when you walk? ☐ Yes ☐ No
Do you have sharp, stabbing or shooting pain in our feet? ☐ Yes ☐ No

What provides relief of Pain or sensation?_____

_____

_____

_____

_____

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Headache Migraine Part 1b

Van Harding L.Ac.
2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064 310-310-8096 tel/fax info@vanharding.com

Name_____ **Age**____ **Sex**_____**Date**_____

Headache & Migraine - Part 1c

****** For each question, check all the boxes that apply to you (ie you may check more than 1 box)***

ONSET

1. Did you suffer from headaches when you were younger?
   - □ As a child
   - □ As a teenager
   - □ In my 20's – 40's
   - □ In my 50's or 60's

   When were your headaches at their worst? _____

2. When did your current headache problem begin?
   Headaches became a problem _____ Months □ Years □ ago.

3. Precipitating Event - *Was there a precipitating event or trigger for your current headache problem?*
   - □ None known
   - □ Specific stress _____
   - □ Injury _____
   - □ Motor vehicle accident _____
   - □ Illness _____
   - □ Menarche (first period)
   - □ Pregnancy
   - □ Birth Control Pill
   - □ Hormone Replacement
   - □ Other _____

HEADACHE CHARACTERISTICS:

4. Frequency of headaches - *On average, how often do you have headaches?*
   They occur _____ times each □ Day □ Week □ Month
   Are they increasing in frequency? □ Yes □ No
   They are more frequent on:
   □ Weekdays □ Weekends
   □ Spring □ Summer □ Fall □ Winter

5. Onset of each headache:
   Headaches typically begin: □ Gradually □ Suddenly □ Varies
   They usually begin in the: □ Morning □ Afternoon □ Evening □ Night
   How long before they reach maximal intensity? _____ □ Minutes □ Hours

6. Duration of the headaches:
   Headaches usually last (with medication) ____ □ Minutes □ Hours □ Days
   Headaches usually last (without medication) ____ □ Minutes □ Hours □ Days

7. Intensity of the headaches - H*ow bad are your headaches*?
   With medication: □ Mild □ Moderate □ Severe □ Incapacitating
   Without medication □ Mild □ Moderate □ Severe □ Incapacitating
   Headaches prevent activities □ School □ Work □ Household chores

8. Location of Headaches - *Where do you feel the pain during your headaches*?
   □ Left side □ Right side □ May be either side □ Both sides □ Other _____
   □ Forehead □ Temple □ Behind eye(s) □ Back of head □ Neck

9. Pain Type - *What does the headache pain feel like?*
   □ Pressure □ Stabbing □ Throbbing □ Other _____
   □ Tight band □ Burning □ Dull ache

10. Headache Triggers - *Do any of the following **bring on/trigger** your headaches?*

- ☐ Foods (specific food triggers will be discussed later in the questionnaire)
- ☐ Too much caffeine ☐ Not getting enough caffeine
- ☐ Hunger / Skipping meals ☐ Alcohol ☐ Wine
- ☐ Fatigue ☐ Too little sleep ☐ Too much sleep (sleeping in)
- ☐ During stressful times ☐ After stress (first day of vacation, weekend, after a test)
- ☐ Menstruation
- ☐ Exercise ☐ Sexual activity ☐ Coughing
- ☐ Prolonged computer work ☐ Weather changes
- ☐ Certain Odors ☐ Bright lights/sun ☐ Loud sounds

Other _____

11. Premonitory Symptoms - *Do you experience any of the following **before** your headache begins?*

- ☐ Mood changes ☐ Personality changes ☐ Other _____
- ☐ Change in appetite ☐ Food cravings
- ☐ Neck pain ☐ Fatigue ☐ No, I don't experience any of these

12. Aura Symptoms - *Do you ever experience any of these warning symptoms **before** your headache begins?*

- ☐ Bright lights / flashes of lights/ multi-colored lights (circle applicable description)
- ☐ Zig-zag lines ☐ Partial loss of vision / blurry vision / blindness (circle applicable)
- ☐ Numbness / tingling ☐ Paralysis
- ☐ Dizziness or vertigo ☐ Upset stomach / nausea ☐ No I don't have these

13. Associated Symptoms - *Do you experience any of these symptoms **during** your headaches?*

- ☐ Nausea / upset stomach ☐ Vomiting
- ☐ Bright lights/sun bothers you ☐ Loud sounds bother you
- ☐ Strong smells/odors bother you
- ☐ Dizziness / lightheadedness / vertigo (circle applicable description)
- ☐ Numbness or tingling
- ☐ Increased sensitivity of Scalp / Hair / Ears
- ☐ Eye tears ☐ Runny or stuffy nose
- ☐ Difficulty concentrating ☐ Mood changes / irritability

14. Alleviating Factors - *During a headache, what makes you feel the most comfortable?*

- ☐ Lying down / sleeping ☐ Being in a dark quiet room
- ☐ Keeping physically active ☐ Pacing back-and-forth
- ☐ Massage your head ☐ Tying something around your head
- ☐ Cold pack on your head/neck ☐ Hot pack on your head/neck

HEADACHE-RELATED DISABILITY:

15. Effect of headaches on ability to function:

a) During Milder headaches:

- ☐ I am able to function normally
- ☐ My ability to function is slightly decreased
- ☐ My ability to function is severely decreased
- ☐ I am totally bedridden

b) During moderate or severe headaches:

- ☐ I am able to function normally
- ☐ My ability to function is slightly decreased
- ☐ My ability to function is severely decreased
- ☐ I am totally bedridden

16. Doctor Visits for Headache – *How many times would you estimate that you have visited the following because of your headaches in the past 1 year?*

- ☐ Family physician _____
- ☐ Walk-in clinic _____
- ☐ Emergency department _____

17. How many days of work or school have you missed in the past 1 year because of headaches? _____

Name_____ **Age**____ **Sex**_____**Date**_____

HEADACHE-RELATED INVESTIGATIONS

18. Previous Testing - *Have you had any of the following tests done to investigate your headaches? If yes, please indicate the approximate date and results:*

- ☐ CAT Scan _____
- ☐ MRI _____
- ☐ EEG _____
- ☐ Sinus X-rays _____ ☐ Neck X-rays _____
- ☐ Other _____

19. Previous Consultations - *Have you seen any of the following about your headaches? If yes, please give the name, and approximate date*:

- ☐ Neurologist
- ☐ Ear, nose and throat specialist
- ☐ Dentist
- ☐ Psychiatrist
- ☐ Pain Clinic
- ☐ Eye doctor
- ☐ Internal medicine
- ☐ Allergy specialist

_____

HEADACHE-SPECIFIC TREATMENT

20. Multi-Disciplinary Health Care - *Have you seen any of the following about your headaches?*

- ☐ Chiropractor
- ☐ Massage therapist
- ☐ Acupuncturist
- ☐ Psychologist
- ☐ Naturopath / homeopath / herbalist
- ☐ Nutritionist
- ☐ Physiotherapist
- ☐ Other _____

21. Headache-Related Purchases - *Have you purchased any of the following to try to treat your headaches?*

- ☐ Hot packs
- ☐ Aromatherapy
- ☐ Herbs / Herbal supplements
- ☐ Cold packs
- ☐ Naturopathic medicines
- ☐ Anti-inflammatory rubs
- ☐ Eye masks
- ☐ Headache self-help book
- ☐ Mouth-guard
- ☐ None of these
- ☐ Other _____

22. Headache Relief from Medications - *How long does it take before you become pain-free after taking your current headache medications?*

☐ Within 1 hour ☐ 1 – 2 hours ☐ > 2 hours ☐ I never become pain-free after medication

23. Current Headache Medications - *Please include all Over-The-Counter and Prescription Medications/Pain Relievers that you are **CURRENTLY** using to **TREAT** your headaches (do not include preventative medication)*:

Medication Name & dose	Average & Maximum used in 1 day	How many days used per month	Side-effects	% of time effective
i.e. Tylenol (325 mg)	Average 4; Max 10 tablets	10 days per month	None	
1.				
2.				
3.				
4.				
5.				
6.				

Name_____ **Age**____ **Sex**_____**Date**_____

24. Current Headache Preventative Medications - *Please include all Prescription and Herbal Products that you are* ***CURRENTLY*** *using to* ***PREVENT*** *your headaches:*

	Medication Name	Dose	Side-Effects
1.	.....	.....	.....
2.	.....	.....	.....
3.	.....	.....	.....
4.	.....	.....	.....

25. Previously Tried Headache Medications - *Please include all Over-The-Counter and Prescription Medications that you have* ***PREVIOUSLY*** *used to TREAT(not prevent) your headaches but have stopped using:*

	Medication Name	Daily Dosage	Reason for Stopping
1.	.....	.....	.....
2.	.....	.....	.....
3.	.....	.....	.....
4.	.....	.....	.....
5.	.....	.....	.....
6.	.....	.....	.....
7.	.....	.....	.....
8.	.....	.....	.....

(If list exceeds 8, attach an additional paper with a list of all previously used headache pain medications)

26. Previously Tried Headache Preventative Medications - *Please include all Prescription and Herbal Products that you have* ***PREVIOUSLY*** *used to* ***PREVENT*** *your headaches:*

	Medication Name	Daily Dosage	Reason for Stopping
1.	.....	.....	.....
2.	.....	.....	.....
3.	.....	.....	.....
4.	.....	.....	.....
5.	.....	.....	.....
6.	.....	.....	.....
7.	.....	.....	.....
8.	.....	.....	.....

(If list exceeds 8, attach an additional paper with all previously used preventative medications)

Name_____ **Age**____ **Sex**_____**Date**_____

HEADACHE-SPECIFIC QUALITY OF LIFE QUESTIONNAIRE

Please answer each of the following questions by checking the most appropriate answer (1 per question):

1. In the past 4 weeks, how often have headaches interfered with how well you dealt with family, friends and others who are close to you?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

2. In the past 4 weeks, how often have headaches interfered with your leisure time activities, such as reading or exercising?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

3. In the past 4 weeks, how often have you had difficulty performing work or daily activities because of headache symptoms?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

4. In the past 4 weeks, how often did headaches keep you from getting as much done at work or at home as you would like?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

5. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities.

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

6. In the past 4 weeks, how often have headaches left you too tired to do work or daily activities?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

7. In the past 4 weeks, how often have headaches limited the number of days you have felt energetic?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

8. In the past 4 weeks, how often have you had to cancel work or daily activities because you had a headache?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

Name_____ **Age**____ **Sex**_____**Date**_____

HEADACHE-SPECIFIC QUALITY OF LIFE QUESTIONNAIRE

9. In the past 4 weeks, how often did you need help in handling routine tasks such as every day household chores, doing necessary business, shopping, or caring for others, when you had a headache?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

10. In the past 4 weeks, how often did you have to stop work or daily activities to deal with headache symptoms?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

11. In the past 4 weeks, how often were you not able to go to social activities such as parties or dinner with friends because you had a headache?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

12. In the past 4 weeks, how often have you felt fed-up or frustrated because of you headaches?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

13. In the past 4 weeks, how often have you felt like you were a burden on others because of your headaches?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

14. In the past 4 weeks, how often have you been afraid of letting others down because of your headaches?

None of the time	☐	**Some of the time**	☐
Most of the time	☐	**All of the time**	☐

Name_____ **Age**____ **Sex**_____**Date**_____

Headache-Related Nutrition Questionnaire

1. Are you aware of any specific food triggers that can cause your headaches? Please list:

_____
_____
_____
_____

2. If you are aware of food triggers, how did you become aware of your triggers? Please check all that apply, and provide detail if necessary:

- □ Observation/instinct _____
- □ Trial and error _____
- □ By completing food/symptom diaries _____
- □ Suggestion from MD, dietician, naturopath _____
- □ Other (provide details) _____

3. Have you made any changes to your eating behaviours to help control your headaches?

- ◻ Strictly avoid specific trigger foods (list foods): _____
- ◻ Try to avoid certain trigger foods, but tend to be inconsistent (list):
  _____
- ◻ Reduced my caffeine intake from _____ to _____
- ◻ Changed meal frequency (provide details; how consistently?) _____
- ◻ Added breakfast: (yes/no; how frequent?) _____
- ◻ Improved my hydration (how much more fluid, what types?): _____

4. Please describe your weight:

- □ My weight has been fairly stable (within 10 lbs) in my adult life
- □ My weight has increased over the years
- □ My weight has gradually declined over the years
- □ My weight tends to fluctuate up and down

5. Do you diet, follow weight loss programs, or visit weight loss centres (e.g. Weight Watchers, low carb, Bernstein, Fuel for Life, Atkins, etc.)?

- □ Never or almost never
- □ Yes, I've tried a few diets, diet centres, or programs
- □ Frequently. I usually try a few diets or programs each year
- □ I'm constantly dieting

6. Do you currently, or have you ever tried supplements (vitamins, minerals, herbs) to help control your headaches? Please list:

SUPPLEMENT	DOSE (IF KNOWN)	LENGTH OF TIME TAKEN	IMPACT

Name_____ **Age**____ **Sex**_____**Date**_____

Physical Activity Questionnaire

Do you engage in regular physical activity? ☐ **Yes** ☐ **No**

Do you have access to a fitness gym? ☐ Yes ☐ No ☐ Commercial ☐ Home ☐ Private studio ☐ Condominium ☐ Work ☐ Other ……..	Do you have a personal trainer/fitness coach? ☐ Yes ☐ No Name/contact info (if desired): ……

Equipment/Facilities Available (whether currently used or not):

Cardiovascular	Strength Training	Sports Equipment/Facilities
☐ Treadmill	☐ Free Weights	☐ Squash/Tennis courts
☐ Stationary Bike	☐ Machines	☐ Golf Course/range
☐ Track	☐ Resistance Bands	☐ Skiing
☐ Elliptical	☐ Physio balls	☐ Pool
☐ Other:	☐ Other:	☐ Other:
……	……	……..

Current Physical Activities:

Cardiovascular			Strength		
Modes/Type of Training:			**Modes of Training:**		
☐ Treadmill ☐ Stationary Bike ☐ Walking/Jogging	☐ Swimming ☐ Elliptical ☐ Sports (please list): ……..		☐ Machines ☐ Free Weights ☐ Other (please list): …….		
How many minutes per day?	☐ 10 to 20 ☐ 20 to 30 ☐ 30 to 40 ☐ 40 to 60 ☐ 60+		**How many minutes per day?**	☐ 10 to 20 ☐ 20 to 30 ☐ 30 to 40 ☐ 40 to 60 ☐ 60 +	
How many times per week?	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ 5 ☐ 6 ☐ 7 ☐ More ……..	**How many times per week?**	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ 5 ☐ 6 ☐ 7 ☐ More ……..
Intensity:	☐ High ☐ Moderate ☐ Low ☐ HR Zones: High …… Low …… Avg …… ☐ Interval Training: Ratio high:low ……		**Set Routine:**	☐ Yes ☐ No Sets ……..….. Reps …… Rest between sets ……..…	

Sports You Participate In:

Activity	Yrs Participated	Highest Level of Competition	Current Level of Competition
		☐ Recreational ☐ Competitive ☐ Professional	☐ Recreational ☐ Competitive ☐ Professional
		☐ Recreational ☐ Competitive ☐ Professional	☐ Recreational ☐ Competitive ☐ Professional
		☐ Recreational ☐ Competitive ☐ Professional	☐ Recreational ☐ Competitive ☐ Professional
		☐ Recreational ☐ Competitive ☐ Professional	☐ Recreational ☐ Competitive ☐ Professional

Name_____ **Age**____ **Sex**_____**Date**_____

Psychology Questionnaire – Headache

STRESS MANAGEMENT:
Please describe any recent life stressors (e.g. health, relationships, financial, work)?

How do you cope with stress in your life (e.g., physical exercise, meditation, relaxation)?
How helpful are these techniques at managing your current level of stress?

Is it often hard for you to relax and unwind? ☐ **Yes** ☐ **No**

FUNCTIONAL ASSESSMENT:
In the past month have you….

Yes	No	
☐	☐	Had periods of time when you feel down or depressed?
☐	☐	Felt less interested in doing things you normally like to do?
☐	☐	Head periods of excessive energy, mood swings, increased irritability and/or loss of concentration?
☐	☐	Been worrying excessively about a number of things?
☐	☐	Felt very nervous or anxious or suddenly experienced a lot of physical symptoms (e.g., heart racing, sweating)?
☐	☐	Had a fear of losing control of yourself or "going crazy"?
☐	☐	Avoided social situations for fear of what others may think or say about you?
☐	☐	Been afraid of leaving your home alone, or being home alone?
☐	☐	Had repeated thoughts or images in your head that are difficult to dismiss?
☐	☐	Felt compelled to complete certain behaviours repeatedly (e.g., checking to make sure you locked the doors, washing your hands again an etc.)?
☐	☐	Thought a lot about or relived an upsetting event from the past?
☐	☐	Found yourself preoccupied with food, weight or body image?
☐	☐	Been concerned about your use of alcohol or medication/drugs?

Have you been in therapy before or received any prior professional assistance for emotional, psychological relationship issues? ☐ **Yes** ☐ **No** If yes, please describe, starting with most recent/current

Dates	Duration/# of sessions	Physician/Therapist	Type of Therapy/Treatment (marriage counseling, group sessions, etc

Have you ever been diagnosed with a psychological condition (e.g. clinical depression)? ☐ **Yes** ☐ **No**
If yes, please describe.

Thank you for taking the time to complete this form. Your responses will be treated as private and confidential.

Van Harding L.Ac.
2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064 310-310-8096 tel/fax info@vanharding.com

Name_____ **Age**____ **Sex**_____**Date**_____

PATIENT OPINIONS/QUESTIONS:

1. What type of headache(s) do you think you have?

_____
_____

2. Do you have any specific concerns/fears about your headaches?

_____
_____
_____

3. What specific questions do you have for Van Harding?

(a) _____

(b) _____

(c) _____

(d) _____

(e) _____

(f) _____

(g) _____

Thank-you for taking the time to complete this important questionnaire.

Name:_____ Date_____

Use the next four (4) pages to embellish upon the details of your PAIN and Life Experiences.

Headache & Migraine - Part 2

Primary Complaint

Instructions: The Day your Headache/Migraine became disruptive to your ADL or caused significant impairment

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order starting with the morning of and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012. Then describe the following:

- where you were located when you noticed the Headache/Migraine (or a medical diagnosis that was given),
- how you felt and any emotional responses
- what ADL you could not do or what bodily functions were significantly impaired
- the duration of the Physical Sensation(s) and characteristics (qualities)
- anything that seemed to make it worsen or improve it
- any observations by other people of your behavior, emotions or physical condition

Date your Headache/Migraine or associated symptoms became disruptive to your ADL or caused significant impairment:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Headache Migraine Part 2

Name:_____ Date_____

Headache & Migraine - Part 3

Primary Complaint

Instructions: Your Life Prior to the Day the Headache/Migrain became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back to the earliest date when you noticed the Physical Sensation and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your Headache/Migraine became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moving your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarceration institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date of earliest recall of Headache/Migraine or associated symptoms:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Headache Migraine Part 3

Name:_____ Date_____

Headache & Migraine - Part 4

Primary Complaint

Instructions: Your Life 1 year Prior to the Earliest Date you noticed the Headache/Migraine or associated symptoms cited in Part 3.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back 1 year prior to the earliest date when you noticed the Headache/Migraine and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your Headache/Migraine became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarcerated institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date 1 year prior to the earliest recall of the Headache/Migraine or associated symptoms:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Headache Migraine Part 4

Van Harding L.Ac.
2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064 310-310-8096 tel/fax info@vanharding.com

Name:_____ Date_____

Headache & Migraine - Part 5

Primary Complaint

Instructions: Your Symptoms and Actions since the day your Headache/Migraine or associated symptoms became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Describe to best of you abilities the chronological sequences of the following starting from the Day the Headache/ Migraine or associated symptoms became disruptive to your ADL or caused significant impairment through to today. Include the following:
  - changes of the symptoms over time (duration, intensity, improvements, worsening, etc)
  - the actions you have employed to treat the problem via MD, ND, DO, DC, LAc, PT and other therapists as well as home remedies. Include the diagnosis, therapies, medications and natural remedies (herbs, homeopathy, nutritional) that have been used. Include any and all improvements or worsening of the problem/condition due to any of the actions you employed.
- Include the events of your life that occurred during this tme period. These events include:
  travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarcerated institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Symptoms and Actions since the Headache/Migraine or associated symptoms became disruptive to ADL or causative to significant impairment.

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Headache Migraine Part 5

Van Harding L.Ac.
2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064 310-310-8096 tel/fax info@vanharding.com