Producer: _____ Phone: _____ Fax: _____

Client: _____ Age/DOB: _____ Sex: _____

If your client has headaches, please answer the following:

1. Date when first diagnosed.

_____

2. What type of headache was diagnosed?

- ☐ Migraine
- ☐ Cluster
- ☐ Tension
- ☐ Other: _____

3. Was your client incapacitated from work due to the headache?

- ☐ Yes. If yes, when and for how long? _____
- ☐ No

4. Please describe frequency of attacks.

_____

_____

5. Please give date of most recent attack.

_____

6. Is your client on any medications?

- ☐ Yes. (Please give details.) _____
- ☐ No

7. Has your client smoked cigarettes in the last 12 months?

☐ Yes ☐ No

8. Does your client have any other major health problems (e.g., heart disease, etc.)?

- ☐ Yes. (Please give details.) _____
- ☐ No