

Migraine Questionnaire

Name: _____ B-Day: _____ Age: _____ Sex: M F

Email: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

How did you hear about our office? _____

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- ▶ We do not treat headaches, symptoms or diseases.
- ▶ A headache is an attempt by your body to tell you something.
- ▶ We will attempt to find the underlying headache trigger.
- ▶ We do not use drugs in this program.
- ▶ There is no single “healthy” diet that will work for everyone.
- ▶ Just because a food is considered “healthy” does not mean it is “healthy” for you.
- ▶ Our procedures are safe and painless

Briefly describe the reason for your visit and what you hope to accomplish: _____

Current Medications: _____

Previous Treatments: _____

Family members with migraine headaches: _____

Please put a check next to all that apply:

- Head pain is getting more severe recently
- Headaches started after age 40
- Drowsiness associated with headache
- Severe headaches started less than 1 year ago
- Increase in frequency over last year
- Confusion associated with pain
- Fever associated with pain
- Rapid decline in strength
- Recent increase in blood pressure.
- Certain body positions cause headaches
- Has a doctor ever told you that you have a brain tumor
- Do you suspect you may have a brain tumor?

Do any of the following cause a headache?

- Physical exertion
- Straining
- Coughing
- Sexual Activity

Please check all that apply:

- Pain affects 1 side of the head
- Starts in the morning, get worse in the afternoon and evening
- Feels like a constricting band
- May last for days
- Location may vary with each headache
- Manual pressure can make the headache worse
- Associated with stress
- Pain is usually on one side of the head
- Often occurs at times of letdown, such as weekends, vacations
- Throbbing penetrating pain
- Often accompanied by a sick or nauseated feeling or vomiting
- May last a few hours or days
- May be accompanied by sensitivity to light, sound and odors
- Nose may run
- May flush and sweat
- May see flashing lights or halos around objects
- Starts around menstrual cycle
- Pain is located behind the eye
- Headaches are seasonal and tend to start at the same time of the year
- May have several attacks a day for weeks, then none
- Pain comes on with little or no warning
- Usually one sided, but may change sides
- Pain is piercing or burning
- Attacks last 30-45 minutes
- Eye tears, swells, droops
- May cause flushing or sweating on one side of the face
- Nostril on affected side becomes congested
- Pain is above or below the eyes, may spread to forehead and cheeks
- May be seasonal
- Starts in morning, gets worse as the day goes on
- Pressure like pain
- Nose feels congested
- May be accompanied by discharge from nostrils or postnasal drip
- Area often may be tender to the touch
- Fever may be present
- May follow upper respiratory infection

At what age did headaches begin? _____

Was there any trauma (emotional, physical, or chemical) occurring at that time? If yes, please explain.

When are your headaches worse?

- Outdoors, and better inside
- At nighttime, in the bedroom or when in bed
- During windy weather
- During wet or damp weather
- When the weather changes
- During known pollen seasons
- In certain rooms or buildings
- When exposed to tobacco smoke
- With yard work, cut grass, leaves, hay or barns
- When sweeping or dusting the house
- In areas with mold or mildew
- In air conditioning In fields or in the country
- Tobacco smoke bothers me more than anything else
- Don't know

Age when headache symptoms were first observed

- Infant (Age 0 - 2)
- Child (Age 3 - 5)
- Child (Age 6 -12)
- Adolescent (Age 13 - 18)
- Young Adult(Age 19 - 25)
- Adult (Age 26 - 40)
- Adult (Age 40+)

What type of pain do you have with the headache?

- Sharp
- Stabbing
- Burning
- Dull Ache
- Throbbing
- Band-like Tightness

What visual symptoms do you have with your headache?

- Bright light circles around objects
- Flashes of light
- Odd light patterns
- Double vision
- Spots before eyes
- Loss of some vision
- Loss of all vision

How often do you get a headache? _____

How long do your headaches last?

- Minutes
- Hours
- Days
- Weeks

Is there a time of day that your headaches are more likely to start?

- No pattern, can start anytime
- I wake up at night with a headache
- I often wake up with a headache in the morning.
- During the morning
- Before lunch
- After lunch
- If I don't eat lunch
- Before Dinner
- After dinner
- Before bedtime

Do you have nausea or vomiting associated with the headache?

- Before the headache
- During the headache
- After the headache

How is your energy level overall?

- Great in the morning when I wake up
- Better if I take a nap in the afternoon
- Terrible when I wake up
- Worse after I take a nap
- Better in the morning

Y N

Has there ever been a time when your headaches just went away, then came back for no apparent reason?

If Yes, how long ago and for what length of time? _____

- 1. Do you feel more tired if you sleep late in the morning?**
- 2. Do you get fatigued if you stop moving and sit for more than 20 minutes?**
- 3. Do you have days of feeling okay and suddenly become exhausted and you descend into feelings of despair?**
- 4. Do you want to be alone in the evenings?**
- 5. Do you feel as if you have never totally been yourself?**
- 6. Do you have bouts of cloudy thinking or mental fog?**
- 7. Do you have dark shadows under your eyes?**

Y N

- 8. Do you have bouts of depression for no apparent reason?
- 9. Do bright lights make the pain worse?
- 10. Do you become sensitive to smells when you have a headache?
- 11. Do movements make the headache pain worse?
- 12. Do you have any numbness when you have a headache?
- 13. Do you go into a darkened room and lie motionless until the headache passes?
- 14. Do environmental factors trigger your headaches? (Rain, heat, cold)?
- 15. Do you know of anything in your diet that can trigger a headache? Please list:

- 16. Do you know of any triggers other than your diet that can cause a headache?

- 17. Do your headaches get worse around or after the holidays?
- 18. How often do you get a severe headache? _____
- 19. How often do you get a regular headache? _____
- 20. Did your first severe headache start after some type of *physical* trauma?
- 21. Did your first severe headache start after some type of *emotional* trauma?
- 22. Did your first severe headache start after some type of *chemical* exposure?
- 23. What do you do when you get a severe headache? _____
- 24. What makes your headache go away? _____
- 25. List the medications you have tried that did not help you:

- 26. Do you have neck pain?
- 27. Have you ever had anyone work on or manipulate your spine?
- 28. Can body movement or positioning bring on a severe headache?
- 29. Have you ever had an auto accident? If yes, when? _____
- 30. When is your energy at highest? _____
- 31. When is your energy at its lowest? _____
- 32. Do you get tired after eating a big meal?
- 33. Do allergies run in your family?
- 34. Do you have chronic sinus problems?
- 35. Do you get recurring joint pains?
- 36. Do you get recurring muscle pains?
- 37. Do you have restless legs in the evening?

Y N

- 38. Do you have recurring rashes?
- 39. Do you have anxiety?
- 40. Do you have dizziness?
- 41. Do you have gas? If yes: Stomach? Lower bowel?
- 42. Do you have depression?
- 43. Do you have ringing in the ears?
- 44. Do you have chronic constipation?
- 45. Do you feel bloated after eating?
- 46. Do you have chronic diarrhea?
- 47. Did your first severe headache start after some type of dental work?
- 48. Did your first severe headache start after childbirth?
- 49. Did your first severe headache start after an injection or vaccination?
- 50. Does putting gasoline in your car seem to affect you? How? _____
- 51. Do strong odors like perfume seem to trigger some of your severe headaches?
- 52. Does drinking alcohol affect your severe headaches?
- 53. Do you wear perfume/aftershave?
- 54. Do you use skin lotions or moisturizers?
- 55. Do you feel like the headaches have ruined the quality of your life?
- 56. Have the headaches affected your relationships?
- 57. Have the headaches affected your work?
- 58. Have the headaches affected your family?

Please select the description below that best describes the pain level of a severe headache:

- Level 1:** Bad head pain, but I can still function as if everything is okay. I usually feel depressed at this point.
- Level 2:** Moderately bad head pain with some mild stomach symptoms, (mild nausea, vomiting, diarrhea). I can still function okay in routine activities such as typing, driving or preparing dinner. Starting to lose my grip and my thinking is getting muddled.
- Level 3:** Awful head pain with pronounced stomach distress. Light sounds and odors make my head hurt worse. I can't think clearly and I don't think I'm going to be good for anything much longer. I feel so bad I could cry.
- Level 4:** Excruciating head pain, vomiting, impaired reasoning, and sensitivity to light, sounds, odors and motion. I'm incapable of functioning at all now. I am in agony. All I want is to be lying down in a dark quiet room.

Patient waiver and Release

I, _____ hereby consent to treatment of my triggers or sensitivities using the Computerized ElectroDermal Screening (CEDS) system by **Dale Kelly, D.C.** located at 655 Greenbrae Drive, Suite C, Sparks, NV 89431

Background: I desire to be tested to determine possible undesirable reactions to various substances that are natural constituents of my diet, environment or body chemistry. I understand that the testing procedure to be used is not generally employed by the majority of physicians for this purpose. I understand that other methods of testing and treatment are available. These have been described to me. **Procedures:** I understand that this is a non-invasive procedure where the skin is not pierced. Metal conductors are attached to the skin to measure electrical conductivity on the hands. Additional homeopathic remedies; nutritional supplements and other natural remedies may be used to bring abnormal electrical patterns into equilibrium. I understand the nature of related symptoms are of an unpredictable nature and therefore this facility cannot guarantee any results. Dale Kelly, DC cannot guarantee the success nor the longevity of this therapy. I choose to be tested using the CEDS system. I understand that CEDS testing has not been scientifically proven to be reliable and that my physician must still rely upon my personal observation as to the effectiveness of the test and any treatment based on the results of this test. **Risks:** The procedure is very safe because it measures only changes in the electrical properties of the skin. However, since an electrical signal is used there is a slight, risk of electrical burn or shock. Skin irritation or redness may occur at the site of the test. However, any discomfort should be brief. There are generally no risks associated with the substances recommended to bring your body to equilibrium as long as these substances are taken as recommended. I agree to immediately report any discomfort I may experience from taking these substances to my examiner or physician. I agree I have reported any and all significant health problems (i.e., Diabetes, High Blood Pressure, etc) to my physician. I understand that sensitivities may increase during therapy. I assume all responsibility for any unpredictable immunity response and understand that this facility does not treat cases of anaphylaxis and I agree to completely disclose all information regarding any life threatening allergies or allergies resulting in anaphylaxis. **Questions:** I have been provided with the opportunity to ask any pertinent questions I have regarding the CEDS testing procedure, protocol, and/or treatment program. **Free to Decline:** I understand that I may decline to participate in the CEDS testing and can choose instead to have other testing. **Important:** There is no recognized body of scientific evidence to show that an electrically balanced body is more likely to be healthier and you have chosen to participate in this assessment with that understanding. Your physician may need to use other forms of testing in the course of your treatment. **Payment of Service:** You are responsible for the payment of the normal and necessary fees associated with the CEDS and any remedies, supplements, or herbals recommended as a result of that testing, if purchased in this clinic. **I have read and understand the above information about CEDS and my rights and responsibilities and hereby consent to the use of the CEDS System.** I consent to the use of clinical reports and results of case for study, the purpose of advancing clinical knowledge, research and scientific purposes, provided that my identity is kept confidential.

The facility and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary changes to prescribed medications during or after the treatment.

No, I do not have any life threatening allergies that may cause anaphylaxis

Yes, I do have the following allergies that may cause anaphylaxis: _____

I agree to render payment for any and all treatment administered

Signature of Patient

Signature of Parent or Legal Guardian

Date