

Headache Patient Self-Assessment

When were you last seen? _____

How many headaches have you had since your last visit? _____

How many headaches do you have per month? _____

Have you noticed a change in the pattern with your headaches? _____

What do you usually take when you have a headache? _____

On a scale of 1-10, what number is your headache when you decide to treat it? _____

When you treat your headache, does the first dose work or do you have to repeat it? _____

If you have to repeat it, how long do you wait before re-dosing? _____

What percent of time do you have to take a second dose? _____

Have you missed work/school/family functions due to headaches? _____

Are you satisfied with your headache control? _____

What questions do you have for today? _____