[Standard Header]

Claimant Name: [Clmt Full Name]

PLEASE COMPLETE AND RETURN BY {clmt_form_return_date}

HEADACHE QUESTIONNAIRE

If you need more space, please attach additional page(s).

1) When did you start having headaches? (Approximate date) ____________________________

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____

2) What is the date of your last headache?

____

3) What causes your headaches? ____

____

____

4) Describe a typical headache:

a) Type (for example, migraine, sinus, cluster) ____________________________________

b) Location (for example, front, temple, middle, side, back) __________________________

c) Symptoms (for example, nausea, vomiting, blurred vision) _________________________

____

5) How often do you get headaches? (for example, daily, weekly, monthly) ________________

____

____

6) How long does a typical headache last? ____

____

____

7) Describe any limitations in your activities during a typical headache and how long these limitations last (for example, darkened room, lying without moving, sleep disturbance).

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____

8) List current headache medication(s).

MEDICATION, DOSAGE, and FREQUENCY	DATE STARTED	IF PRESCRIBED, NAME OF HEALTH CARE PROFESSIONAL	SIDE EFFECT(S)

9) Do you take the medication as prescribed? ☐ Yes ☐ No

If no, explain why: ___________________________________

____

____

10) Which of your medications help to alleviate or eliminate your headache symptoms and how long does it take for the medication to take effect?

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11) Have you visited an emergency room for treatment to relieve a headache? If so, when and where? ____

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12) Do you use any other treatments to relieve your headaches? If so, describe.

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13) List at least two people who have observed at least one of your typical headache events:

Name: ______________________________ Phone No: ______________________________

Name: ______________________________ Phone No: ______________________________

14) If you have seen any health care professionals for your headaches since you filed your claim, complete the chart below.

HEALTH CARE PROFESSIONAL NAME	ADDRESS AND PHONE NUMBER	DATE OF LAST VISIT AND NEXT SCHEDULED APPOINTMENT (IF ANY)

15) If you listed names and contact information in response to questions 13 and 14, do we have your permission to contact them? ☐ Yes ☐ No

______________________________ ______________ ______________

Name of person completing this form (please print) Date Phone

Address

City

State

Zip Code