FORT COLLINS Headache Center

PATIENT INTAKE - SUPPLEMENTAL FORM

PATIENT INFORMATION

NAME	DATE	TELEPHONE

Please, list the names of any healthcare professionals you or your family see:

☐ GP / FAMILY DOCTOR	______	☐ PHYSICAL THERAPIST	______
☐ DENTIST (IF OTHER)	______	☐ CHIROPRACTOR	______
☐ ORAL/MAXILLOFACIAL SPECIALIST	______	☐ MASSAGE THERAPIST	______
☐ PSYCHIATRIST/PSYCHOLOGIST	______	☐ OTHER	______

Please review and answer any part that applies for each question.

GENERAL QUESTIONS

1 Were you referred by someone? ☐ Yes ☐ No

» If Yes, who referred you to our office? ______

» What is their relationship to you? ______

2 Are you presently under the care of a doctor or taking any prescriptions? ☐ Yes ☐ No

» If Yes, physician's name(s): ______

» What condition(s) are you being treated for? ______

» What treatment / medication(s) are you taking? ______

3 Do you have any problems with your jaw? ☐ Yes ☐ No

☐ Clicking ☐ Popping ☐ Grinding ☐ Jaw Injury ☐ Jaw Locks Open
☐ Jaw Locks Closed or Partially Closed

» If injury, when and how did this injury occur? ______

» If not injury, how long have you had these problem(s): ______

» How you previously received treatment for this problem(s): ☐ Yes ☐ No

» If yes, who directed this treatment? ______

Mark the type of treatment(s) below and provide details:

☐ Bite Splint - Result: ☐ Good ☐ Fair ☐ Poor

☐ Medication - Result: ☐ Good ☐ Fair ☐ Poor

☐ Physical Therapy - Result: ☐ Good ☐ Fair ☐ Poor

☐ Occlusal Adjustment - Result: ☐ Good ☐ Fair ☐ Poor

☐ Orthodontics - Results: ☐ Good ☐ Fair ☐ Poor

☐ Surgery - Results: ☐ Good ☐ Fair ☐ Poor

☐ Other ______ - Results: ☐ Good ☐ Fair ☐ Poor

4 Do you have pain in any of the following areas?

☐ Jaw Joints ☐ Jaw Muscles ☐ Muscles Under the Side of Jaws
☐ Ears ☐ Temples (Side of Head) ☐ In or Behind the Eyes
☐ Back of Neck ☐ Side of Neck

5 Do you consider yourself to be under more stress than most people? ☐ Yes ☐ No

HEADACHE HISTORY AND DETAILS

1 Where are your headaches located?

☐ Temples (sides of head) ☐ Occipital (back of head)
☐ Frontal (front of head) ☐ Top of head

2 How severe are your headaches?

☐ Mild ☐ Moderate ☐ Severe

3 Describe the type of headache pain you feel most often:

☐ Achy ☐ Throbbing ☐ Stabbing ☐ Other ______

4 Duration of headaches:

» How long do your headaches normally last? _____ hours _____ days

» How long would they last, if you did nothing to abate them? ______

5 Do you take medications for headaches? ☐ Yes ☐ No

» What medication(s) are you taking? ______

» Dosage: Describe how much and how often? ______

» After medicating, how long does it take for the headache to go away?

6 Do you try non-medicating techniques for managing your headaches? ☐ Yes ☐ No

☐ Yoga ☐ Breathing Exercises ☐ Cold Packs ☐ Massage
☐ Physical Therapy ☐ Other (please describe) ______

7 Have you been diagnosed with Migraines? ☐ Yes ☐ No

» How long ago were you diagnosed? ______

» What did the doctor recommend for treatment? ______

» Did the treatment help? ☐ Yes | ☐ No

When finished, please return to our office staff.