Headache Wellness Center

1414 Yanceyville St. Greensboro NC 27405 (336) 574-8000 FAX (336)574-8008
www.headachewellnesscenter.com

Research Questionnaire

Name_____ Date of Birth: __/__/____

Address_____

_____

Phone #: (____) _____ Email address: _____

Are you currently participating in a clinical trial? Yes___ No ____

Best hours to contact you: _____How did you hear about us: _____

Gender: ____Male ____ Female Height: ___ft ___in Weight _____lbs

In a 28 day period, how many days to you have headaches? _____days _____ don't know

In a 28 day period, how many days to you have migraines? _____days _____don't know

Describe your headaches by checking all those that apply:

My headache pain is: _____mild _____moderate _____severe

The pain is usually: _____throbbing _____ pulsating _____ constant

Do you have sensitivity to: _____light _____ sound _____ motion?

Do you experience: _____ nausea _____ vomiting?

My headaches usually last ____ hour's ____ days

How old were you when your headaches began? _____ yrs.

Are you currently being treated for your headaches? _____yes _____no

Have your ever been diagnosed with any of the following:

____ Tension Headaches ____ Migraines ____ Cluster Headaches ____

____ Menstrual Migraines ____ Other _____

Please check any of the following medications that you are currently taking:

___ Amerge	___ Axert	___ Bellerga	___ Cafergot	___ DHE	___ Frova
___ Imitrex	___ Lidocaine	___ Maxalt	___ Relpax	___ Zomig	___ Calan
___ Inderal	___ Norvasc	___ Atenolol	___ Depakote	___ Keppra	___ Clonazepam
___ Lamictal	___ Lyrica	___ Neurontin	___ Topamax	___ Zonegran	___ Cymbalta
___ Desipramine	___ Effexor	___ Elavil	___ Lexapro	___ Wellbutrin	___ Zoloft