NeurocarePlus
18300 Katy Freeway Ste. 405
Houston, TX 7750

Headache Patients Questionnaire

Name:_____Date of Birth:_____

Address:_____City_____

State _____ Zip Code_____ Home Phone: _____

Do you suffer from headaches? Yes ☐ No ☐

Are they migraines? Yes ☐ No ☐

How many days of headache a month? _____

How severe on a scale of 0 to 10? _____

How many hours does your headache last each time? _____

During headaches do you experience:

Nausea? Yes ☐ No ☐ Vomiting? Yes ☐ No ☐

Sensitivity to light? Yes ☐ No ☐ Sensitivity to noise? Yes ☐ No ☐

What type is your headache? Pressure ☐ Pulsating ☐

Is your headache on: One side? ☐ Both sides? ☐

List all the medications used for headache/migraine:

_____

_____

Have you ever used BOTOX for migraine prevention?_____

Signature_____ Date _____