

## HEADACHES/MIGRAINE QUESTIONNAIRE

Name of person completing questionnaire:		
Applicant's Name:		Date of Birth:
Social Security Number:	Height:	Weight:
Last Doctor's visit:	Any surgeries: <input type="checkbox"/> Yes <input type="checkbox"/> No	Chiropractor: <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s):		Counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No
Any auto/work related injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any other medical conditions or medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- When first diagnosed? \_\_\_\_\_
- What is the frequency of the headaches/migraines and how long do they last? \_\_\_\_\_
- Is there a known cause?  Yes  No
- Any loss of consciousness?  Yes  No
- Any nausea/vomiting?  Yes  No
- Type of treatment? \_\_\_\_\_  
     Current treatment: \_\_\_\_\_  
     How often? \_\_\_\_\_
- Current medications – names, milligrams (pill or shot): \_\_\_\_\_  
     How often is medication taken? \_\_\_\_\_
- Any MRI's or CAT scans done or planned?  Yes  No  
     When? \_\_\_\_\_  
     Results: \_\_\_\_\_
- Has there been any hospitalizations or ER visits for this condition?  Yes  No
- When was the last Doctor visit for this condition: \_\_\_\_\_  
     Doctor's name and address: \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, all statements and answers on this questionnaire are complete and true. If any information should result as false or inaccurate, I understand my coverage will be terminated at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date