Dell Children's Pediatric Headache Center
within UT Health Austin Pediatric Neurosciences
At Dell Children's
Austin, TX 78723

Patient Label

Pediatric Headache Center Intake Form

LAST NAME: _____ FIRST NAME: _____
Date of birth: _____ Date of appointment: _____

What is the primary/major concern you would like to discuss with your doctor today?

What is your goal from this evaluation?

Are there any specific treatments you are interested in or would like to avoid?

Past Medical and Surgical History (please LIST any medical conditions you have, any diagnosis you have received, including mental health diagnoses, and any specialists you see)**:**

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Birth History:
Was your child born: Early Late On Time (Gestational Age: ____ Weeks)
Mode of Delivery: □ Vaginal □ C-Section
Were there any complications with the pregnancy or delivery? □ YES □ NO

Developmental History:
Were your child's major developmental milestones achieved on time? □ YES □ NO

Family History:
Do any members of your family have headaches? □ YES □ NO
If yes, in which members? _____
Is there a family history of brain aneurysms, blood clots, or miscarriages? _____
Any other family history you want to share? _____

Admission Note

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Social History:

Who lives at home with you? _____

What school do you attend and what grade are you in? _____

Is there a 504 or IEP in place (circle which one)? □ YES □ NO

- If yes, do you feel that you have enough support with your IEP/504 plan? □ YES □ NO

Are there any concerns with your attendance or with truancy? □ YES □ NO

Regular exercise: □ YES □ NO

Adequate sleep: □ YES □ NO

Do you have any concerns about your mental health? □ YES □ NO

Have you experienced any major life stressor or event in the past year? □ YES □ NO

- If yes, check the stressor/s below:

☐ death of a close family member, relative, friend, or pet	☐ divorce or separation	☐ birth of a child
☐ marriage	☐ abuse or trauma	☐ conflict or bullying
☐ change in employment	☐ financial changes or difficulties	☐ significant illness
☐ inadequate housing	☐ school change or problems	

Have you had to miss any other activities or events that are important to you because of headaches? □ YES □ NO _____

Do you have any concerns about following treatment recommendations? □ YES □ NO

- If yes, please explain:

Do you have any allergies to medications? □ YES □ NO List: _____

Headache History:

At what age did you start having headaches? _____

When did headaches become more bothersome? _____

Currently, how many days per month are you experiencing ANY type of headache? _____

- How many of these days are severe? _____

How long do your headaches typically last? _____

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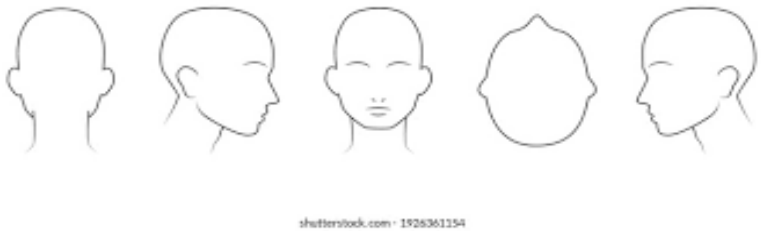
Do you have any warning signs that a headache is coming? □ YES □ NO

- If yes, please describe:

Where does your pain occur (please mark on the pictures below)?



What does your pain feel like? _____

What makes your pain better? _____

What makes your pain worse? _____

Do your headaches happen at a particular time of day or can they start anytime?

What do you think may be causing your headaches?

Please circle any symptoms that occur **with** your headaches:

Sensitivity to light	Lightheadedness	Redness of your eyes
Sensitivity to sound	High-pitched tinnitus	Tearing
Nausea	Pulsatile tinnitus	Congestion
Vomiting	Blurry vision	Runny nose
	Double vision	Facial swelling
	Pain with eye movements	Facial flushing
	Vertigo (feeling the room is spinning)	Changes in pupil size

What is your most bothersome symptom? _____

Please list any symptoms that occur **between** episodes of headache:

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How are your headaches impacting your ability to participate in your daily life?

Do you have pain in other parts of your body? □ YES □ NO
If yes, where does that pain occur?

REVIEW OF SYSTEM: Circle any symptoms that you are currently experiencing.

Mental Status	Neurologic	Systemic
Confusion	Change in smell	Trouble with bowel or bladder control
Memory concerns	Change in vision	Weight gain or loss
Sleep concerns or excessive daytime drowsiness	Weakness in face or limbs	Intolerance to heat or cold
Loss of interest in activities	Altered sensation in face or limbs	Fevers, chills, night sweats
Trouble with speech/language	Altered balance or coordination	Hair loss
Loss of consciousness or fainting	Muscles cramps, twitching, or tremor	Coughing up blood, shortness of breath
	Ringing in ears or trouble hearing	Palpitations, chest pain
	Spinning sensation or lightheadedness	Heartburn/acid reflux
	Difficulty swallowing	Joint pain or swelling
		Abdominal pain, constipation, diarrhea
		Vomiting
		Rashes

MEDICATIONS: please include all **past and current** medications.*
*Please give your best estimate for the start date.

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ACUTE MEDICATIONS (medications you take when you get a headache):

NAME	Currently taking? (Place a check in this column)	Previously tried? (Place a check in this column)	Start Date	Duration	Dose	Any Side Effects?
Tylenol						
Excedrin						
NSAIDs (circle): Advil/Motrin/Ibuprofen Aleve/Naproxen Diclofenac Toradol/Ketorolac Nabumetone						
TRIPTANs (circle): Sumatriptan Oral/Nasal spray/Injection (Imitrex) Rizatriptan (Maxalt) Zolmitriptan Oral/Nasal (Zomig) Almotriptan (Axert) Eletriptan (Relpax) Naratriptan (Amerge) Frovatriptan (Frova)						
Ergotamine Tablets or DHE						
Nasal Spray (Migranal)						
CGRP Antagonists Ubrogepant (Ubrelvy) Rimegepant (Nurtec)						
Ondansetron (Zofran) Prochlorperazine (Compazine) Metoclopramide (Reglan)						
Other:						

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PREVENTIVE MEDICATIONS (medications you take daily to prevent headaches):

NAME	Currently taking? (Place a check in this column)	Previously tried? (Place a check in this column)	Start Date	Duration	Dose	Any Side Effects?
Amitriptyline (Elavil)						
Venlafaxine (Effexor)						
Topiramate (Topamax)						
Valproate or Valproic Acid (Depakote)						
Gabapentin (Neurontin)						
Propranolol (Inderal)						
Verapamil (Verelan, Calan)						
Flunarizine (Sibelium)						
Acetazolamide (Diamox)						
Candesartan (Atacand)						
Cyproheptadine (Periactin)						
Indomethacin (Indocin)						
Lithium (Eskalith, Lithobid)						
Memantine (Namenda)						
Magnesium						
Coenzyme Q10						
Feverfew						
Melatonin						
Vitamin B2 (Riboflavin)						
Botulinum Toxin						
CGRP Monoclonal Antibodies (circle): Erenumab (Aimovig); Galcanezumab (Emgality); Fremanezumab (Ajovy); Eptinezumab (Vyepti)						
Nerve Blocks						
ED Visits/Infusion Center Treatment or Admissions? (list med given if known):						
Other:						

Does anything get in the way of taking medications as prescribed? _____

Pediatric Headache Center Intake Form

ADJUNCTIVE THERAPIES (non-drug therapies):

Type of Treatment	**Current treatment?** (Place a check in this column)	**Previously tried?** (Place a check in this column)	**Date Started & Ended (MM/YEAR)**	**Did you find this treatment helpful?**
Cognitive Behavioral Therapy (CBT)				
Biofeedback or Mindfulness				
Other Psychotherapy, Talk Therapy, or Counseling				
Physiotherapy or Physical Therapy				
Osteopathy				
Homeopathy				
Hypnosis or Meditation				
Reflexology				
Faith Healing				
Massage				
Transcutaneous Nerve Stimulation - Cefaly				
Transcranial Magnetic Stimulation (TMS) - eNeura				
Vagal Nerve Stimulation - gammaCore				
Remote Electrical Neurostimulation - Nerivio				

Please list any other medications, vitamins, or supplements you are currently taking (include dose):

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PedMIDAS

In the past three months:

1. How many days of school were missed due to headache? _____ (0-90 days)
2. How many partial days of school were missed due to headache (do not include full days counted in the first question)? _____ (0-90 days)
3. How many days did you function at less than half your ability in school because of a headache (do not include days counted in the first two questions)?_____ (0-90 days)
4. How many days were you not able to do things at home (e.g., chores, homework, etc.) due to a headache? _____ (0-90 days)
5. How many days did you not participate in other activities due to headache (e.g., play, go out, participate in sports, etc.)? _____ (0-90 days)
6. How many days did you participate in these activities but functioned at less than half your ability (do not include days counted in the fifth question)? _____ (0-90 days)

   Total Score: _____

HIT-6

Please check one box for each question.

1. When you have headaches, how often is the pain severe?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

2. How often do your headaches limit your ability to participate in usual daily activities, including chores, school, sports, or social activities?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

3. When you have a headache, how often do you wish you could lie down?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

4. In the past 4 weeks, how often have you felt too tired to attend school or participate in daily activities because of your headaches?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

6. In the past 4 weeks, how often did your headaches limit your ability to concentrate on schoolwork or daily activities?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Very Often ☐ Always

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To be completed by medical staff:

Total Score: _____