UCSF Child & Adolescent Headache Program
Department of Neurology

CHILD & ADOLESCENT HEADACHE PROGRAM
INTAKE FORM

LAST NAME: _____ **FIRST NAME:** _____

Date of Birth: _____

Date of appointment: _____

Handedness (circle): Right-handed◯Left-handed◯Both◯

Have you updated your **contacts**, including your emergency contact, primary care provider and referring provider details at the front desk/with the headache team? YES ☐ NO ☐

Do you have access to **MyChart** (the electronic patient portal)? YES ☐ NO ☐
https://www.ucsfhealth.org/mychart

If you answered "no" to either question- please update this information with the headache team,

Do you consent to having detailed **voicemail messages** left on your messaging system(s) (i.e., the numbers listed in your medical records) if you are not able to answer the call? YES ☐ NO ☐

Are you interested in learning about any of our **headache research projects**? YES ☐ NO ☐

Who lives at home and who are the patients' **legal guardians** (i.e., who has legal permission to attend appointments and receive medical information): list names, relationship, and guardianship:

_____

What is the REASON for your visit &/or the major concern you would like to discuss today?

Past Medical & Surgical History (***LIST*** any medical conditions you have/diagnoses you have received)

- -
- -

Birth History:

Was your child born (circle): ◯ Early ◯ Late ◯ On-Time (Gestational age: ____ weeks)

Mode of Delivery (circle): ◯ Vaginal ◯ C-Section (reason for C-section: _____

Were there any complications with the pregnancy or delivery? **YES (list)**:_____ **NO** ☐

Developmental History:

Were your child's major developmental milestones (walking/talking) achieved on time? **YES** ☐ **NO** ☐

If no, please explain: _____

Family history:

Do you have a family history of **migraine** or **severe headaches**? **YES** ☐ **NO** ☐

If yes, in which members? _____

Is there a family history of early strokes (<age 50yo), brain aneurysms, brain tumours, or blood clots (if yes, in whom)? _____

Any other family medical history you want to share?_____

Social History:

Grade at school?_____ (as of fall 20___). Is there a **504 or IEP** in place? YES ☐ NO ☐

Regular exercise: YES ☐ NO ☐ Adequate Sleep: YES ☐ NO ☐

Do you have any concerns about your/your child's mental health?

YES (please explain):_____NO ☐

Any history of the following (circle if present): growing pains, motion sickness, ice-cream headache (brain-freeze), frequent childhood stomach pain, frequent childhood vomiting episodes, episodes of dizziness/vertigo, head-tilt as an infant (torticollis), or a history of colic.

REVIEW OF SYSTEMS: <u>Circle all that apply</u>

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

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

CURRENT MEDICATIONS (medications that you/your child are currently taking):

NAME of MEDICATION	**START DATE*** *(DD/MM/YEAR)*	**MAX DOSE?**	**Does it work?** *(Yes or No)*	**Any side effects or concerns?**
AS NEEDED MEDICATIONS *(Acute treatments for pain or other reasons)*				
DAILY MEDICATIONS (*please include all vitamins/supplements)*				
Non-medication THERAPIES**				

Please give your best estimate for the starting date

****Non-medication therapies** include non-drug treatments such as psychology/therapy, massage, mindfulness, chiropractor, acupuncture, etc.*

PAST/PRIOR ACUTE MEDICATONS *(treatments no longer being used):*

NAME	START DATE	DURATION & FREQUENCY of USE	DOSE	Did it work?	Why did you stop? Any Side Effects?
Acetaminophen *(Tylenol)*					
Excedrin (Tylenol, Aspirin, Caffeine)					
NSAID's: Ibuprofen (*Advil/Motrin)*					
Naproxen *(Aleve)*					
Diclofenac *(Zipsor, Cambia, Voltaren)*					
Ketorolac *(Toradol)*					
TRIPTAN's (circle): Sumatriptan Oral, Nasal spray or injection *(Imitrex)* Rizatriptan tablet or melt *(Maxalt)* Zolmitriptan Oral or Nasal *(Zomig)* Almotriptan *(Axert)* Eletriptan *(Relpax)* Naratriptan *(Amerge)* Frovatriptan (*Frova)*					
Ergotamine or DHE Nasal Spray *(i.e., Migranal)*					
Ondansetron *(Zofran)*					
Prochlorperazine *(Compazine)*					
GEPANTS: Ubrogepant *(Ubrevly)* Rimegepant *(Nurtec)*					
DITANS: Lasmiditan *(Reyvow)*					
Acute neuromodulation devices for migraine *(i.e., Cefaly, TMS, VNS, Nerivio)*					
OTHER *(list):*					

PAST/PRIOR PREVENTIVE MEDICATONS *(treatments no longer being used):*

NAME	START DATE	DURATION of USE	DOSE?	Did it work?	Why did you stop? Any Side Effects?
Amitriptyline *(Elavil)*					
Venlafaxine *(Effexor)*					
Topiramate *(Topomax)*					
Valproic Acid *(Depakote)*					
Gabapentin *(Neurontin)*					
Propranolol *(Inderal)*					
Verapamil *(Verelan, Calan)*					
Flunarizine *(Sibellum)*					
Acetazolamide *(Diamox)*					
Candesartan *(Atacand)*					
Cyproheptadine *(Periactin)*					
Indomethacin *(Indocin)*					
Lithium *(Eskalith, Lithobid)*					
Memantine *(Nemenda)*					
Magnesium					
Co-Enzyme Q10					
Feverfew					
Melatonin					
Vitamin B2 *(Riboflavin)*					
Botulinum Toxin					
CGRP monoclonal Antibodies: (circle) *Erenumab (Aimovig); Galcanezumab (Emgality); Fremanezumab (Ajovy); Eptinezumab (Vyepti))*					
Nerve Blocks					
Neuromodulation devices *(Cefaly, TMS, VNS)*					
ED visits/Infusion Center treatment or Admissions? *(list med given if known):*					
OTHER *(list):*					

PAST/PRIOR Non-medication THERAPIES

(These are therapies no longer being used, list current therapies in the "current" section above):

Type of Treatment	**Date Started & Ended (MM/YEAR)**	**Did you/your child find this treatment helpful?**
Cognitive Behavioural Therapy (CBT)		
Biofeedback		
Mindfulness/Meditation		
Other Psychotherapy, Talk Therapy or Counselling		
Physiotherapy or Physical Therapy (PT)		
Osteopathy, homeopathy, natural medicine		
Hypnosis		
Reflexology or Massage		
Faith Healing		

Any other information you wish to share?

DON'T FORGET:

1) Updated your contact information at the front desk/with the headache team/online.

2) Update your pharmacy with the intake headache nurse or medical assistant (MA).

3) Activate MyChart prior to leaving clinic or please do this online prior to your visit.

4) Remember to get a "headache diary". If you didn't get one by email pre-visit, contact us.

5) Book your follow up appointment (if one is recommended).