Doric George M.A.
Board Certified Professional Counselor
Licensed Professional Clinical Counselor #LPC208
Licensed Marriage & Family Therapist #MFC38343

CONFIDENTIAL MIGRAINE QUESTIONNAIRE

Please print out this form and fill it in as completely as you can in your own handwriting.

How did you hear about us? _____ May we thank them? _____

Name: _____

Address: _____

_____

Tel. Home: _____ Work: _____ Cell: _____

Email: _____ Date of Birth: _____ Age: _____ Sex: _____

Relationship Status: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

Children? _____ Names & ages: _____

Education: _____ Fields of interest: _____

Occupation: _____

Hobbies, leisure activities? _____

Do you exercise? _____ How often? _____ What type? _____

Do you have time during the day to set aside for just you? _____

What do you expect from treatment? _____

Have you ever had EMDR or hypnosis before? _____ Results? _____

_____

Do you know anyone else who has? _____ Results? _____

_____

Have you ever been in therapy *(briefly describe)*? _____

_____

_____

Headache Assessment

What type of headaches do you have? _____

_____

Please describe the location, quality and intensity of the pain? _____

_____

How long do they last? _____

When did your headaches begin? _____

Have you noticed a change in your headaches? *(Please describe)* _____

_____

When do you get headaches? _____

How often? _____

Can you feel a headache coming on? _____

How do you know when one is about to start? _____

Can you identify triggers that can bring on a headache? *(e.g. stress, poor sleep, foods, chemicals, time of year, etc.)*

_____

What aggravates or worsens your headaches? *(e.g. bright lights, noise, certain foods, weather, etc.)* _____

_____

Have you ever had a head injury? *(Please describe)* _____

_____

Are your headaches the result of an accident, illness or injury? _____

Please list any diagnoses you have been given? _____

_____

What types of doctors have you seen? _____

What non-drug treatments have you tried? *(e.g. Acupuncture, deep tissue, diet, supplements, etc.)* _____

_____

Please list the medications you have tried, prescription and non-prescription, and when you took them starting with the most recent including the ones you are taking now:

Drug Name:_____Frequency:_____ When:_____

Drug Name:_____Frequency:_____ When:_____

Drug Name:_____Frequency:_____ When:_____

Drug Name:_____Frequency:_____ When:_____

Drug Name:_____Frequency:_____ When:_____

Drug Name:_____Frequency:_____ When:_____

Drug Name:_____Frequency:_____ When:_____

Drug Name:_____Frequency:_____ When:_____

Drug Name:_____Frequency:_____ When:_____

Drug Name:_____Frequency:_____ When:_____

Please list other medical treatments and procedures. *(e.g. MRI, CAT scan, ECT, etc.)* _____

_____

What dietary and lifestyle changes have you tried to help reduce headaches? _____

_____

Do you have trouble sleeping? *(Please describe)* _____

_____

What have you tried to help your sleep?_____

_____

Are you ready to make reducing or perhaps eliminating your headaches a priority?_____

_____

Is there anything else you would like to add that we might have missed? _____

_____

Do you drink coffee or diet soda? _____ How much? _____

Do you smoke? _____ Do you consider yourself overweight?_____

Anxiety/Depression Assessment

Do you feel tired, run down, and out of energy? _____

Do you get angry or irritable? _____Do you cry easily? _____

Are you quick tempered? _____ Do you feel out of control? _____

Are you having trouble leaving the house?_____

Would you describe yourself as worried? _____

What worries you the most? _____

Briefly describe your behaviour when you are worried._____

Do you feel your behaviour is normal when you are worried?_____

Does worry or low energy ever limit you and your activities? _____How? _____

_____

Does worry or low energy interfere your social life or relationships? _____

Can you remember a time when you were not worried or fatigued? _____

What do you remember about that time? _____

Has worry or fatigue ever made you physically uncomfortable? *(Please describe))* _____

_____

Has worry or fatigue caused you embarrassment in any way? *(Please describe))* _____

_____

Is your worry or fatigued job related? *(Please describe)* _____

_____

Is your worry or fatigue family related? *(Please describe)* _____

_____

Do you have any specific fears? *(e.g. flying, driving on freeways, heights, etc.)* _____

_____

_____

What have you tried to help yourself? _____

_____

Medical Information

Are you currently under the care of a physician? ___ Yes ___ No

(If yes, please list name and speciality) _____

_____

Do you have any other medical conditions (Heart problems, blood pressure, diabetes, etc)? ___ Yes ___ No

(Please list) _____

_____

Are you currently taking any other medications? ___ Yes ___ No

(Please list) _____

_____

Have you ever taken any psychiatric medications? (e.g. for depression, anxiety, etc.) ___ Yes ___ No

(Please List) _____

Or have you ever been hospitalized for mental/emotional reasons? ___ Yes ___ No

(Please describe) _____

Ever had severe depression, panic attacks, or seriously considered suicide? ___ Yes ___ No

(Please describe) _____

How much do you drink alcohol? _____

Do you use "Recreational" drugs? *(What & how often?)* _____

Do you have any type of epilepsy? ___ Yes ___ No

Have you recently seen a physician or health professional? ___ Yes ___ No

Are there any medical reasons you shouldn't exercise at all? ___ Yes ___ No

The above information I have provided herein is true and complete to the best of my knowledge and I have revealed all medical and psychological information that might effect my participation in this program. Complete professional confidentiality will always be maintained including the content and the fact of our therapy sessions except under certain circumstances as mandated or allowed by law, such as the presence of a reasonable suspicion of child abuse or a serious danger to client or others.

I understand that Integrated EMDR headache treatment involves physical touch. I agree that if I am ever uncomfortable with the physical touch for any reason, I will immediately alert the practitioner so that adjustments can be made.

Name Printed: _____ Signature: _____ Date: _____