Patient Discussion Guide with Healthcare Practitioner

Headache Diagnosis: _____

My Goals for Living With my Diagnosis: _____

_____

Rate Severity		Mild				Severe		Current Medications	
Symptoms *(Check boxes)*	**N/A**	**1**	**2**	**3**	**4**	**5**		**OTC**	**Has it helped?**
Head pain									Yes/No
Throbbing									Yes/No
Pressure									Yes/No
Nausea									Yes/No
Vomiting									Yes/No
Dizziness								**Rx**	
Aura									Yes/No
Sensitivity to Light									Yes/No
Sensitivity to Sound									Yes/No
Sensitivity to Smells									Yes/No
Other:									Yes/No

Triggers: My symptoms appear when…

- ☐ **I'm stressed**
- ☐ **I don't sleep well**
- ☐ **I don't drink water regularly I have caffeine**
- ☐ **I drink alcohol**
- ☐ **It's before or during my period**
- ☐ **It's too bright inside or outside**
- ☐ **The weather is:**
- ☐ **I smell certain odors:**
- ☐ **I take certain medications:**
- ☐ **Other: _____**

Questions & Concerns

1. **Why am I having attacks if I'm on treatment?**
2. **What are triggers I should know to avoid?**
3. **Which medication options do I have?**
4. **What are signs I need a new medication?**
5. **What should I expect when I switch treatments?**
6. **What lifestyle habits can help prevent my attacks?**
7. **What symptoms are severe enough that I should contact**
8. **Where can I go to get reliable information?**
9. **Other: _____?**

Incidence of Headache-Migraine Attacks This Month

Circle all days with pain, then highlight all days with symptoms.

Month: _____ Year: _____

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

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