Please complete this form before your first appointment. Your answers help us make the most of your session and tailor your assessment from the outset. All information is treated as strictly confidential.

1 Personal Details

Basic information for your patient record

Full Name

Date of Birth

Email Address

Phone Number

Gender

- Female
- Male
- Non-binary
- Prefer not to say

GP / Doctor's Name & Practice (if known)

2 Your Headaches & Migraines

Tell us about your main symptoms

How would you primarily describe your condition?

- Migraine
- Tension-type headache
- Cervicogenic headache
- Cluster headache
- Not sure
- Mix / more than one

How long have you suffered with headaches/migraines?

How often do you get them?

Typical duration of each episode

Typical time of onset

Typical pain intensity during an attack (circle a number)

0	1	2	3	4	5	6	7	8	9	10

None / no pain *Worst imaginable*

Where is the pain usually located? (tick all that apply)

- ☐ Forehead / front of head
- ☐ Temple(s)
- ☐ Behind the eye(s)
- ☐ Top of head
- ☐ Back of head / occiput
- ☐ Neck / base of skull
- ☐ One side only (unilateral)
- ☐ Whole head

What type of pain best describes your headaches? (tick all that apply)

- ● Throbbing / pulsating
- ● Pressure / tightness
- ● Stabbing / sharp
- ● Dull / aching
- ● Burning

3 Associated Symptoms

Symptoms that occur with or around your headaches

Do you experience any of the following? (tick all that apply)

- ☐ Nausea
- ☐ Vomiting
- ☐ Sensitivity to light (photophobia)
- ☐ Sensitivity to sound (phonophobia)
- ☐ Sensitivity to smell
- ☐ Visual aura (zigzags, blind spots)
- ☐ Sensory aura (tingling, numbness)
- ☐ Difficulty speaking during attack
- ☐ Dizziness / vertigo
- ☐ Neck stiffness or pain
- ☐ Shoulder / upper back pain
- ☐ Fatigue / postdrome ("headache hangover")
- ☐ Difficulty concentrating / brain fog
- ☐ Mood changes before or after

Do you experience an aura before your headaches?

- ● Yes, always
- ● Yes, sometimes
- ● No
- ● Not sure

4 Triggers & Patterns

Factors that seem to bring on or worsen your headaches

Do any of the following appear to trigger your headaches? (tick all that apply)

- ☐ Stress / anxiety
- ☐ Poor or disrupted sleep
- ☐ Prolonged sitting / screen use
- ☐ Neck movements or positions
- ☐ Hormonal changes (e.g. menstrual cycle)
- ☐ Certain foods or drinks
- ☐ Caffeine (too much or withdrawal)
- ☐ Dehydration
- ☐ Bright or flickering light
- ☐ Loud noise
- ☐ Weather / pressure changes
- ☐ Physical exertion
- ☐ Alcohol
- ☐ Travel / car journeys

Any other triggers you have noticed?

Does anything reliably help relieve your headaches? (tick all that apply)

- ● Medication
- ● Sleep / lying down
- ● Dark quiet room
- ● Heat on neck
- ● Cold compress
- ● Neck self-massage
- ● Drinking water
- ● Nothing reliably helps

5 Neck & Musculoskeletal History

The upper cervical spine is often involved in headache disorders

Questions about your neck help us assess whether the upper cervical spine may be contributing to your headaches — a key focus of the Watson Headache® Approach used at this clinic.

Do you have current neck pain or stiffness?

○ Yes ○ No ○ Sometimes

Is your neck pain/stiffness related to your headaches?

○ Yes ○ No ○ Not sure

Have you had any of the following? (tick all that apply)

- ☐ Whiplash injury
- ☐ Other neck or head injury
- ☐ Cervical spine surgery
- ☐ Jaw pain / TMJ problems
- ☐ Shoulder or upper back pain
- ☐ None of the above

Occupation / main daily activities

6 Medical History & Medication

Previous investigations, diagnoses, and treatments

Have you seen a doctor about your headaches?

○ Yes ○ No

Have you had a formal headache diagnosis?

○ Yes ○ No ○ Not sure

If yes, what diagnosis were you given?

Have you had any of the following investigations? (tick all that apply)

○ MRI brain / neck ○ CT scan ○ Blood tests ○ Eye test ○ None

Are you currently taking any medication for your headaches? (tick all that apply)

- ☐ OTC painkillers (paracetamol, ibuprofen)
- ☐ Triptans (e.g. sumatriptan, rizatriptan)
- ☐ Preventative medication (e.g. amitriptyline, topiramate)
- ☐ CGRP antagonist / monoclonal antibody (e.g. Ajovy, Emgality)
- ☐ Botox injections
- ☐ No medication

Any other medications or supplements (for any condition)?

Previous treatments tried for headaches: (tick all that apply)

- [ ] Physiotherapy
- [ ] Chiropractic / osteopathy
- [ ] Acupuncture
- [ ] Massage
- [ ] CBT / psychology
- [ ] Neurology referral
- [ ] Specialist NHS headache clinic
- [ ] None

Please briefly describe what helped or did not help with previous treatments

7 Important Safety Questions

Please answer honestly — this helps ensure your safety

If you answer Yes to any of the following, we will discuss this with you before or at your appointment. Some symptoms require medical review before physiotherapy can proceed.

Have you ever experienced a sudden, severe "thunderclap" headache that came on within seconds and felt like the worst headache of your life?	**Yes ■** **No ■**
Have your headaches changed significantly in character, frequency, or severity in the last 4 weeks?	**Yes ■** **No ■**
Do you have any associated neurological symptoms (weakness, numbness, slurred speech, vision loss, or loss of balance) that persist after the headache?	**Yes ■** **No ■**
Do you have headaches associated with fever, neck stiffness, and/or a rash?	**Yes ■** **No ■**
Have you been diagnosed with, or are you being investigated for, cancer, an immune condition, or HIV?	**Yes ■** **No ■**
Have you had a recent head injury, fall, or trauma preceding new or worsening headaches?	**Yes ■** **No ■**

8 Impact & Goals

Understanding how headaches affect your daily life

How much do your headaches impact your daily life? (circle a number)

0	1	2	3	4	5	6	7	8	9	10

None / no pain *Worst imaginable*

Which areas of life are most affected? (tick all that apply)

- ☐ Work / productivity
- ☐ Family / relationships
- ☐ Social life
- ☐ Exercise / sport
- ☐ Sleep
- ☐ Mental health / mood

What are your main goals from attending The Headache Physio?

Is there anything else you would like us to know before your appointment?

How did you hear about The Headache Physio?

○ Google / online search ○ Social media ○ GP / doctor referral ○ Word of mouth ○ Other

Patient Declaration

I confirm that the information I have provided is accurate to the best of my knowledge. I understand this information will be stored securely and used solely for the purpose of planning and delivering my physiotherapy care at The Headache Physio, in accordance with GDPR and NHS data standards. I consent to my information being shared with my GP if clinically appropriate and with my express agreement.

Patient Signature **Date**