Cleveland Clinic Children's
Hospital for Rehabilitation

Behavioral Treatment of Headache

Background Assessment Form

Parent and child/teen: Please complete this form together. Providing this information will best help us teach you skills to prevent and treat your headaches. This is particularly important if you are a new patient to Cleveland Clinic Children's.

Patient's Name: _____ Date: _____ Date of Birth:_____

Referring physician: _____

Social/Educational History:

Please list everyone in the family:

Name	Relationship to Child	Living with the Child?	Age
		Y / N	
		Y / N	
		Y / N	
		Y / N	
		Y / N	
		Y / N	

Name of current school: **Grade in school:**	
Number of extracurricular activities: **Please list activities:**	
Average after school hours spent on school work:	*per day / per week*
Average after school hours spent on extracurricular activities:	*per day / per week*
Average hours spent in employment:	*per day / per week*

Medical History:

Any history of head trauma, meningitis, encephalitis, or other brain injury or neurological condition?	
What headache diagnosis have you been given?	
Any other current medical conditions?	
Any Allergies?	
Any family members with a history of headache or migraine? Please list relationship(s):	

What headache medications has your child taken now or in the past?

Name/dose	Frequency	Date started	Still using?
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
			Y / N
If you use Over-The-Counter medicines (e.g., Advil, Tylenol, Aleve) more than 3x a week… Does headache seem to get worse when you **stop** taking the medication?			Y / N

Psychological History:

	Yes	No	If yes, please explain
Has your child/adolescent ever received mental health services (psychiatrist, psychologist, counselor, etc.)?			
Has your child/adolescent ever been prescribed medication for emotional / behavioral problems?			

Does anyone in your family have a history of:

	Yes	No	If yes, please explain
ADHD or learning disorder			
Anxiety Disorder/Panic Attacks			
Bipolar Disorder (Manic Depression)			
Depression			
Eating Disorders			
Schizophrenia			
Substance/Alcohol Abuse			
Suicide/Suicidal Ideation			
Other:			
Has anyone else in the family ever received mental health services?			

Daily Health Habits:

Sleep	
What time do you usually fall asleep?	School day:
	Summer/weekend:
What time do you usually wake up in the morning?	School day:
	Summer/weekend:
How many total hours do you sleep?	School day:
	Summer/weekend:
Below are a list sleep difficulties that some people with headaches may experience. Please answer yes or no if you experience these sleep difficulties	
Lack of sleep?	
Trouble falling asleep?	
Walking or talking in your sleep?	
Waking at night and trouble falling back asleep?	
Frequent waking at night?	
Feeling not rested or sleepy during the day?	
Other sleep problems?	
Exercise	
What do you do for physical exercise?	
Are you involved in any sports or other activities requiring physical exercise?	
On average, how much exercise do you get in a week (e.g., 30 min 3 times per week)?	
Nutrition	
Give an example of what you typically eat for breakfast:	
Give an example of what you typically eat for lunch:	
Give an example of what you typically eat for dinner:	
How often to you eat "junk food" (candy, chips, ice cream, etc):	_____/per week
How often to you eat "fast food":	_____/per week
How much water do you drink per day:	
Do you ever skip meals? Why?	
Any foods you avoid? Why?	