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:**<br>**Grade in school:** | |
| **Number of extracurricular activities:**<br>**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? | |