



Patient Name: _____

DOB: _____

UPDATED INFORMATION

Please review the following sections and indicate if there have been any changes since your last visit.

Address: _____

City, State & Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

PCP & Phone Number: _____

Pharmacy Name & Address: _____

Insurance Information

Primary Insurance: _____ Member ID #: _____

Subscriber's Name: _____ Subscriber's Date Of Birth: _____

Relationship to Patient: _____

Secondary Insurance: _____ Member ID #: _____

Subscriber's Name: _____ Subscriber's Date Of Birth: _____



Patient Name: _____

DOB: _____

Medical History:

Please indicate any changes in your medical conditions:

Any tests, treatments or procedures? _____

Medications currently taking: _____

Anything additional the doctor should know? _____

Patient Name _____

HIT-6 Questionnaire (Evaluation of headache disability)

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

INSTRUCTIONS : To complete, please circle one answer for each question.

1. When you have headaches, how often is the pain severe?

Never Rarely Sometimes Very often Always

2. How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

Never Rarely Sometimes Very often Always

3. When you have a headache, how often do you wish you could lie down?

Never Rarely Sometimes Very often Always

4. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

Never Rarely Sometimes Very often Always

5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

Never Rarely Sometimes Very often Always

6. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Never Rarely Sometimes Very often Always

Column 1	Column 2	Column 3	Column 4	Column 5
6 points	9 points	10 points	11 points	13 points
each	each	each	each	each

To score, add points for answers in each column. **Total Score:** _____

Class I: 36-49, **Class II:** 50-55, **Class III:** 56-59, **Class IV:** 60 and more.
It suggested to talk to your physician for class II and more.