PEDIATRIC
HEADACHE
CENTER
OF RICHMOND

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: _____

PEDIATRIC
HEADACHE
CENTER
OF RICHMOND

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

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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

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

Never Rarely Sometimes Very often Always

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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

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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

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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 each	9 points each	10 points each	11 points each	13 points 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.