Date: _____ **GP/Walk-in clinic**: _____

Name: _____ Height: _____ Weight: _____

Follow-Up Symptoms

This form is intended to provide the healthcare team with information about your current concerns.

1. Top three concerns to be addressed during today's visit:

1.	2.	3.

2. Have you had any new diagnoses since your last visit?
   [ ] No
   [ ] Yes _____

3. Has there been a change in your medications since your last visit?
   [ ] No
   [ ] Yes _____

4. List current medications/dosage:

5. Since your last visit, have you experienced problems with:

[ ] Vision
[ ] Fatigue
[ ] Bladder
[ ] Bowel
[ ] Speech
[ ] Hearing
[ ] Memory (short/long term)
[ ] Mood and thought disturbances
[ ] Muscle spasticity/stiffness
[ ] Pain
[ ] Sexual function
[ ] Relapse (appearance of new or worsening of old symptoms lasting at least 24 hours)
[ ] Climbing/descending stairs
[ ] Mobility
[ ] Transfers
[ ] Bathing
[ ] Grooming
[ ] Dressing
[ ] Feeding
[ ] Coordination
[ ] Balance

For those on injectable drugs:
[ ] Problems at injection site
[ ] Side-effects
[ ] Missed injection

Headache Questionnaire

Name: _____

Length of time you have suffered from headaches: _____Days _____Months _____Years

Headache duration

[ ] < 2 hrs [ ] 2 – 72 hrs [ ] over 72 hrs

Frequency (headaches per month)

[ ] < 2 [ ] < 4 [ ] < 8 [ ] < 16 [ ] > 16

Site of pain

[ ] One side [ ] Both sides [ ] Beginning on one side and spreading to the other

Type of pain

[ ] Throbbing/Pulsating [ ] Burning [ ] Tightening or pressing [ ] Goes away with sleep

Severity of pain

[ ] Mild [ ] Moderate [ ] Severe

Is the pain aggravated by routine physical activity? [ ] Yes [ ] No

Other symptoms:

[ ] Nausea
[ ] Vomiting
[ ] Aura i.e. Flashes of light or blurred vision or "zig-zag" patterns
[ ] Sensitivity to light
[ ] Sensitivity to smell
[ ] Sensitivity to sound

How many days in the last month did you have a headache? _____ Days

Have you identified any migraine triggers? _____.

On a scale of 0 – 10, on average how painful were these headaches?
(0 = no pain at all, and 10 = pain as bad as it can be)

0 1 2 3 4 5 6 7 8 9 10

How many days in the last 3 months did you miss work or school, or your productivity was reduced by half because of your headaches? _____ Days

How many days in the last 3 months did you NOT do work around the house, or your productivity was reduced by half because of your headaches? _____ Days

How many days in the last 3 months did you miss family, social, or leisure activities because of your headache? _____ Days

In a month how many days are you **completely free** of headaches? _____ Days

Have you had new or different headaches in the past 6 months? [ ] Yes [ ] No

Please mark the preventative and abortive agents you have tried.

Preventative Agents	**Dose**
[ ] Betablocker such as Propranolol, Nadolol Metoprolol, or Atenolol	
[ ] Nortriptyline, Amitriptyline	
[ ] Topiramate (Topomax)	
[ ] Gabapentin (Neurontin)	
[ ] Epival (Divalproex sodium) Valproic Acid (Depakene)	
[ ] Verapamil, Flunarizine (Sibelium)	
[ ] Cymbalta (Duloxetine)	
[ ] Effexor (Venlafaxine)	
[ ] Sandomigran	
[ ] Other	

Abortive Agents	**Dose**
[ ] Sumatriptan (Imitrex)	
[ ] Zolmitriptan (Zomig)	
[ ] Frovatriptan (Frova)	
[ ] Eletriptan (Relpax)	
[ ] Naratriptan (Amerge)	
[ ] Rizatriptan (Maxalt)	
[ ] Almotriptan (Axert)	
[ ] Tylenol (Acetaminophen)	
[ ] Non-steroid anti-inflammatory medication – (i.e., Naproxen)	

Non-Pharmacological Treatments

[ ] Acupuncture
[ ] Chiropractic Therapy
[ ] Massage
[ ] Physiotherapy
[ ] Other

Thank you for taking the time to complete this questionnaire

PHQ-9 – Nine Symptom Checklist

Name: _____ Date: _____

Over the last **2 weeks**, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

2. Feeling down, depressed, or hopeless
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

3. Trouble falling or staying asleep, or sleeping too much
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

4. Feeling tired or having little energy
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

5. Poor appetite or overeating
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

GAD-7 Screening Questions

Name: _____ Date: _____

During the last **2 weeks**, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

2. Not being able to stop or control worrying
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

3. Worrying too much about different things
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

4. Trouble relaxing
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

5. Being so restless that it is hard to sit still
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

6. Becoming easily annoyed or irritable
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

7. Feeling afraid, as if something awful might happen
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

If you off checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?
[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult