Your Personal Information: Please make sure to provide a valid email address

Print Name: _____
First Last

Address: _____
Street, City, Province, Postal Code

Phone #'s: _____ Yes / No _____ Yes / No
Home Ok to leave VM? Mobile Ok to leave VM?

E-mail: _____

Family Doctor/Medical Clinic: _____Phone: _____

Alberta Health Card # _____ Date of birth MM/DD/YY: _____

Current Gender Identity? ☐ Male ☐ Female ☐ Transgender Male/Transman/FTM
☐ Transgender Female/Transwoman/MTF ☐ Gender Queer ☐ Decline to answer

Emergency Contact/Relation Phone: _____ Emergency Phone #: _____

Health Insurance Company: _____

Name: _____ Group #: _____

Family/Social History - Please check off any that apply (multiple checks are good to know)

Are you: Married Single Divorced Widowed Separated

Are you: Employed Self-employed Unemployed

Are you on currently on income assistance or short-term disability:

- ❑ Income Assistance – Federal Name: _____
- ❑ Income Assistance – Provincial Name: _____
- ❑ Veteran: VACID: _____
- ❑ WCB: Claim#: _____
- ❑ Disability Insurance Name: _____

Was this a WORKPLACE injury that is causing you pain? Yes / No

If yes, please explain when and how?_____

Was this injury due to a car accident that is causing you pain? Yes / No

If yes, please explain when the accident occurred and how the accident happened?

_____

_____

_____

Family Medical History:

- ❑ Father:_____
- ❑ Mother:_____
  _
- ❑ Sibling(s): _____
- ❑ Grandparents:_____
- ❑ Aunts/Uncles/Cousins:_____

Past Surgical History - Please check off any that apply (multiple checks are good to know) Please add date and type of surgery in space provided.

- ❑ Neurosurgery: _____
- ❑ Dental/Jaw/OralMax Surgery: _____
- ❑ Cervical Neck: _____
- ❑ Abdominal: _____
- ❑ Back Surgery: _____
- ❑ Joint Replacement: _____
- ❑ Joint Arthroscopy:_____
- ❑ Pelvic Surgery:_____

Past Medical Health History - Please check off any that apply (multiple checks are good to know)

Have you been recently or previously diagnosed with cancer/malignancy?

- ❑ Type of Cancer: _____
- ❑ Location of Cancer: _____
- ❑ Chemo/Radiation Dates: _____
- ❑ Surgery Plans: _____

Are you currently pregnant or planning a pregnancy or postpartum?

- ❑ Gestational Age (weeks): _____
- ❑ OB/GYN Name & Clinic Fax:
  _____
- ❑ Due Date: _____
- ❑ Breastfeeding Plans: _____

Neurological Health	**Respiratory Health**	**Cardiovascular Health**
❑ Dizziness/Balance problems ❑ Vision problems ❑ Hearing loss ❑ Seizure/epilepsy disorder ❑ Myasthenia Gravis ❑ Parkinson's Disease ❑ Multiple Sclerosis ❑ Migraines ❑ TBI/Post-Concussions ❑ Post-Herpetic Neuralgia ❑ Trigeminal Neuralgia ❑ Stroke/Post-Stroke Pain ❑ Guillain Barre Syndrome ❑ Spinal Cord Injury ❑ Memory Loss/Dementia	❑ Shortness of breath/chest pain ❑ COPD ❑ Bronchitis ❑ Asthma ❑ Emphysema ❑ Do you smoke ? Yes/No How much per day? _____ ❑ Are you on Home Oxygen therapy? Yes /No How much Oxygen are you on? _____ ❑ Do you use a CPAP machine?	❑ High blood pressure ❑ Low blood pressure ❑ Congestive heart failure ❑ Chest pain (angina) ❑ History of heart attack (MI)I ❑ Bypass Grafting/Angioplasty ❑ Atrial Fibrillation ❑ SVT ❑ Heart Disease ❑ Pacemaker or ICD ❑ Valvular Heart Disease ❑ Heart Surgery: _____ ❑ Current Blood thinners: ❑ Warfarin ❑ Dabigatran ❑ Plavix ❑ Heparin ❑ LMWH ❑ Aspirin
Mental Health	**GI Health**	**Women's Reproductive Health**
❑ Sleep Disorders/ Insomnia ❑ Restless Leg Syndrome ❑ Nightmares ❑ Panic Attacks ❑ Agoraphobia ❑ Generalized Anxiety Disorder ❑ PTSD ❑ Depression ❑ Suicidal Attempt Recent/Past ❑ Adjustment Disorder ❑ Bipolar Disorder ❑ Schizophrenia/ Psychosis ❑ Eating Disorder/Anorexia/Bulimia ❑ Autism Spectrum Disorder ❑ ADHD/ ADD ❑ Other:_____	❑ Abdominal Pain ❑ Nausea/ Vomiting ❑ Constipation Yes / No Bowel Movements Frequency per week/per month?_____ ❑ Diarrhea Yes / No Frequency per day?_____ ❑ Ulcerative Colitis/IBD/Crohn's Disease ❑ Irritable Bowel Syndrome ❑ Celiac Disease ❑ Hepatitis/ Liver Disease ❑ Pancreatitis ❑ Colorectal Disease/Diverticulitis	❑ Pelvic Pain/ Gonadal Pain ❑ Vaginal Discharge ❑ Menstrual Irregularity ❑ Heavy Menstrual Bleeding ❑ PCOS ❑ Endometriosis ❑ Premenstrual Syndrome ❑ Hot flashes ❑ Dyspareunia-Painful Intercourse **Men's Genitourinary Health** ❑ Enlarged Prostate ❑ Urinary Bladder Pain ❑ Blood /Pus in urine ❑ Increased frequency of urination ❑ Night time urination ❑ Poor Stream

_____ _____		❑ Incontinence ❑ Sexual dysfunction

Location of Headaches:

☐ Unilateral - right temporal and back of the ear and pain supraorbital

☐ Bilateral ☐ Retro-Orbital ☐ Temporal ☐ Parietal

☐ Occipital ☐ Facial

Quality of Headaches:

☐ Throbbing ☐ Steady Pressure ☐ Sharp ☐ Electric ☐ Burning

☐ Radiates to frontal and goes to the back of the head and goes to the left

Frequency of Headaches:

☐ Every day, all day

Duration of Headaches:

☐ > 8 hours < 18 hours ☐ >18 hours < 24 hours ☐ 48-72 hours

☐ Other: lasts for 72 hours and then gets a break and it restarts - has a headache every day

Associated Symptoms with Headaches

☐ Photophobia ☐ Phonophobia ☐ Osmophobia ☐ Nausea

☐ Cutaneous Allodynia

Focal, Temporary and Fully Reversible Auras:

☐ Blurry Vision ☐ Visual Loss ☐ Scintillation (flashes - sparkles - zig zags)

☐ Dysphasia/ Dysarthria

Any Autonomic Features:

☐Ptosis &/or Miosis - yes ☐ Periorbital eyelid edema - right eye ☐ Restlessness/Agitation - yes

Triggers for Headaches:

☐ Light / noise/smell ☐ Lack of sleep ☐ Stress / Anxiety

☐ Weather ☐ Skipping Meals ☐ Dehydration

☐ Other: physical fatigue

Location of Additional Joint/Muscle Pain:

☐ Cervical Neck ☐ Arm Pain ☐ Shoulder Pain ☐ Jaw/TMJ ☐ Sternum/Chest/Rib Pain

Medication Review - Please check off any that apply (multiple checks are good to know)

Please list all current medications and previous medication and indicate how helpful they have been on a scale of 1 to 10 (1 being not helpful at all, 10 being the most helpful).

Medication Name (Ex: Tylenol ES)	**Administration Dose and Time Prescribed** (Ex: 500mg 1 tablet 4 times a day)	**Scale 1 to 10**

If applicable, please fill :

Chronic Migraine Preventative Medication Trial - Please describe side effects if applicable	**Yes**	**No**
Amitriptyline 25 mg		
Discontinued?		
Side Effects:		
Propranolol 10 mg		
Discontinued?		
Side Effects:		
Candesartan 8 mg		
Discontinued?		
Side Effects:		
Topiramate 25 mg		
Discontinued?		
Side Effects:		

The Migraine Disability Assessment Test

The **MIDAS** (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS

Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

_____ 1. On how many days in the last 3 months did you miss work or school because of your headaches?

_____ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

_____ 3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

_____ 4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

_____ 5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

_____ Total (Questions 1-5)

What your Physician will need to know about your headache:

_____ A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)

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

Scoring: After you have filled out this questionnaire, add the total number of days from questions 1-5 (ignore A and B).

MIDAS Grade	Definition	MIDAS Score
I	Little or No Disability	0-5
II	Mild Disability	6-10
III	Moderate Disability	11-20
IV	Severe Disability	21+