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|  | MIND METHOD CLIENT INTAKE FORM |  |  |
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|  | |  |  | | --- | --- | | **Age of 1st migraine attack?** | **Trigger of 1st migraine attack?** | | **Other family members suffer from migraines?** | **How many days/month do you have attacks?** | | **How long does your migraine last on average?** | **What’s the distribution (in %) per side: (Please estimate a percentage left and right)** | | **Where do you experience the majority of your migraine pain? (Please describe)**   * Behind your eye (left) * Above your eyebrow (left) * On the temple (left) * On the back of your head (left) * Nose * Behind your eye (right) * Above your eyebrow (right) * On the temple (right) * On the back of your head (right) | **How painful are your migraine attacks? (On a scale of 1-10, with 1 being no pain and 10 being excruciating pain)** | | **Is your migraine related to changes in the weather?**   * Always * Sometimes * Never | **Do you wake up at night due to migraine pain?**   * Always * Often * Sometimes * Never | | |  |

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| **Have you ever suffered one or more of the following symptoms before or during a migraine attack?**   * Vomiting * Vomiting combined with diarrhoea * Diarrhoea (without vomiting) * Watering eyes * Dizziness * Swelling of the eyelids * Problems concentrating * Numbness in the skin * Sight disorders (double vision, flashes, zigzag lines, blurred vision, other) * Nausea * Sensitivity to light * Sensitivity to noise * Muscle weakness * Increased sweating * Speech defects * Loss of consciousness (fainting) * Increased nasal secretion * Low blood sugar * Other, please state… | **Do you suffer from increased sensitivity to pain before or during a migraine attack (allodynia)?**   * My hair 'feels' painful * I have to wear my hair down or put it up (remove hairclips, hairbands, etc.) * I no longer use hair curlers/straighteners * I sometimes let my hair float in the bath to get some relief from my headache * I have to cut my long hair off in order to reduce the weight on my scalp * The feeling of rain/showers/water falling on my head is painful * I find it painful to wear anything on my head (e.g. hat, glasses) * Eye shadow is uncomfortable * I cannot wear headphones during my migraine attack * During a migraine attack, I find wearing blankets uncomfortable * My fingers feel painful on contact with everyday items * My sensitivity to pain has increased over recent years * Other, please state… |

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| **What gives you relief during a migraine attack?**   * Rest * Vomiting * Sport/exercise * Sleep * Darkness * Television * Warm water * Cold water * Music * Massage * Reading * Pain-killers * Other, please state | **What triggers or exacerbates (worsens) your migraine?**   * Noise * Physical exertion * Irregular or late meals * Certain foods * Change of weather * Smells * Fatigue (tiredness) * Too much or too little sleep * Light * Stress * Coughing * Pain-killers * Other, please state |
| **If you are a women, is/was your migraine affected by the following? If so, in what way?**   |  |  | | --- | --- | | Menstruation (monthly periods) | Please choose...  improvement  deterioration  no change | | The contraceptive Pill | Please choose...  improvement  deterioration  no change | | Hormone tablets (eg HRT for menopause) | Please choose...  improvement  deterioration  no change | | Pregnancy | Please choose...  improvement  deterioration  no change | | |
| **Have you ever had one of the following conditions?**  Stomach ulcers / Asthma / Eczema / Depression / Allergies (including food allergies) / IBS / ulcerative colitis / other gut conditions including stomach bugs or food poisoning (please state) | |

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| **Have you ever been examined and treated by a doctor for your migraines?**   * Yes * No | **How many times did you see a doctor last year about your migraines?**   * None * 1 - 4 * 5 - 10 * more than 10 |
| **Do you take medications for your migraines?**   * Yes * No   **If yes, please state...** | **Do these treatments help you?**   * Always * Often * Sometimes * Never |
| **Which tests have you had for your migraine?**   * EEG (electroencephalogram) * CT (Computer Tomography) * MRT * Blood tests * X-ray * ECG | **Which of the following approaches have you used in the past?**   * Homoeopathy * Psychotherapy * Relaxation exercises * Mindfulness * Migraine cushions * Cold compact * Hypnosis * Herbal remedies * Nutritional therapy * Acupuncture * Osteopathy * Other (state) |
| **Do you do anything to prevent a migraine attack from occurring?**   * Music to relax * Muscle relaxation * Exercise * Complementary medicine * Administer local pain relief (gel, cream etc) * Medication * Other (state) |

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| **Of the above approaches, have you used any of them consistently for 3+ months? If so, please describe the protocol and how the approach reduced the severity and frequency of migraines** | |
| **Have you had any of the following tests done?**   * HTMA (hair and tissue mineral analysis) * Gut microbiome test * Food intolerance test * Other nutritional test, please state | **If you’ve had any of the tests to the left done, please describe the results** |
| **How much water do you drink a day?**   * Less than 1 highball glass (100ml) * 1 - 3 highball glasses (100 – 300ml) * 3 - 8 highball glasses (300 – 800ml) * 8 - 15 highball glasses (800ml – 1.5litres) * 15+ highball glasses (>1.5 litres) | **How much refined sugar do you consume a day?** (Please note refined sugar is in most packaged foods, tins, jars, sugary drinks, sauces, bought salad dressing etc) |
| **How many days were you absent from work last year due to migraines?**   * Less than 3 days * 4 - 7 days * 8 - 14 days * 15 - 21 days * More than 3 weeks | **How many events or appointments (including nights out, lunches, excursions, holidays, kids parties etc) did you miss last year due to migraines?**   * Less than 5 * 5 - 10 * More than 10 |
| **Thank you for completing this form, please email it as an attachment to** [**nicci.parry@gmail.com**](mailto:nicci.parry@gmail.com) | |