HEADACHES MEDICAL SOURCE STATEMENT

From: _____

Re: _____ (Name of Patient)

_____ (Social Security No.)

Please answer the following questions concerning your patient's headaches. *Attach all relevant treatment notes, laboratory and test results as appropriate.*

1. Frequency and length of contact:_____

2. Diagnoses:_____

_____

3. Does your patient have headaches? Yes ☐ No ☐

   a. If yes, what ***type*** of headache does your patient have?

   ☐ Migraine ☐ Vascular tension ☐ Cluster ☐ Post concussion syndrome

   ☐ Other: _____

   b. Please describe the ***intensity*** your patient's headaches:

   ☐ Mild☐ Moderate -- inhibits but does not wholly prevent usual activity

   ☐ Severe – prevents all activity

4. Identify any other signs and symptoms associated with your patient's headaches:

☐ Nausea	☐ Mental confusion	☐ Visual disturbances
☐ Vomiting	☐ Inability to concentrate	☐ Impaired sleep
☐ Phonophobia	☐ Mood changes	☐ Impaired appetite
☐ Photophobia	☐ Exhaustion	☐ Weight change
☐ Throbbing pain	☐ Malaise	☐ Pain worse with activity
☐ Alteration of awareness	☐ Vertigo	☐ Causes avoidance of activity
	☐ Numbness	

   ☐ Other: _____

_____

5. If there are premonitory symptoms or aura, please describe:

_____

_____

6. What is the approximate ***frequency*** of headaches? _____ per week/ _____ per month

7. What is the approximate ***duration*** of a typical headache? _____ minutes/ _____ hours

8. Identify any impairments that could reasonably be expected to explain your patient's headaches:

- ☐ Anxiety/tension
- ☐ Cerebral hypoxia
- ☐ Cervical disc disease
- ☐ History of head injury
- ☐ Hypertension
- ☐ Intracranial infection or tumor
- ☐ Primary migraines
- ☐ Seizure disorder
- ☐ Sinusitus
- ☐ Substance abuse

☐ Other _____

_____

9. What triggers your patient's headaches?

- ☐ Alcohol
- ☐ Bright lights
- ☐ Hunger
- ☐ Food - identify:

_____
_____
_____

- ☐ Lack of sleep
- ☐ Menstruation
- ☐ Noise
- ☐ Stress
- ☐ Strong odors
- ☐ Vigorous exercise
- ☐ Weather changes

☐ Other: _____

_____

10. What makes your patient's headaches worse?

- ☐ Bright lights
- ☐ Coughing, straining/bowel movement
- ☐ Moving around
- ☐ Noise

☐ Other _____

_____

11. What makes your patient's headaches better?

- ☐ Lie down
- ☐ Take medication
- ☐ Quiet place
- ☐ Dark room
- ☐ Hot pack
- ☐ Cold pack

☐ Other _____

_____

12. To what degree do emotional factors contribute to the severity of your patient's headaches?

☐ Not at all ☐ Somewhat ☐ Very much

Please explain: _____

13. To what degree can your patient tolerate work stress?

☐ Incapable of even "low stress" work ☐ Capable of low stress work
☐ Capable of moderate stress - normal work ☐ Capable of high stress work

Please explain the reasons for your conclusion: _____

14. Describe the treatment and response: _____

_____

_____

15. Identify side effects of medications experienced by your patient:

_____

_____

16. Prognosis: _____

17. Have your patient's impairments lasted or can they be expected to last at least twelve months? Yes ☐ No ☐

18. During times your patient has a headache, would your patient generally be precluded from performing even basic work activities and need a break from the workplace?
Yes ☐ No ☐

If no, please explain: _____

19. If your patient will sometimes need to take unscheduled breaks during a working day:

1) how ***often*** do you think this will happen? _____

2) how ***long*** (on average) will your patient have to rest before returning to work? _____

3) on such a break, will your patient need to ☐ lie down or ☐ sit quietly?

20. Not counting breaks, how much is your patient likely to be **"*off task*" *while at work***? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks?

☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

21. Are your patient's impairments likely to produce "good days" and "bad days"?
Yes ☐ No ☐

If yes, assuming your patient was trying to work full time, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

☐ Never	☐ About three days per month
☐ About one day per month	☐ About four days per month
☐ About two days per month	☐ More than four days per month

22. Are your patient's impairments (physical impairments plus any emotional impairments) ***reasonably consistent*** with the symptoms and functional limitations described in this evaluation? Yes ☐ No ☐

23. Please describe any other limitations (such as limitations in the ability to sit, stand, walk, lift, bend, stoop, crouch, limitations in using arms, hands, fingers, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

_____

_____

_____

_____

_____

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____