

# Headache / Migraine Questionnaire

**Claims Administrator:**  
 Consociate • Dansig  
 Attn: Underwriting  
 111 E. Decatur Street, P.O. Box 1068  
 Decatur, IL 62525  
 Phone: (888) 242-4357  
 Fax: (217) 451-9088

Group name: \_\_\_\_\_

Employee name: \_\_\_\_\_

Dependent name (if condition is for dependent) \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

1. What type of headaches do you suffer from? Cluster, migraine, sinus or other? \_\_\_\_\_

\_\_\_\_\_

2. Any cause determined for them, i.e. stress, allergy related, brain lesion? \_\_\_\_\_

\_\_\_\_\_

3. Length of time you have had these headaches? \_\_\_\_\_

Frequency of headaches? \_\_\_\_\_

Incapacitating/disabling? \_\_\_\_\_

4. When first diagnosed? \_\_\_\_\_ How? \_\_\_\_\_

5. Special testing done (EEG, Cat Scan, MRI, X-rays, Physical)? \_\_\_\_\_

\_\_\_\_\_ Results: \_\_\_\_\_

\_\_\_\_\_

6. Treatment to date: \_\_\_\_\_

\_\_\_\_\_

Medication name	Dosage	Frequency	Currently?		When stopped
			Yes	No	
_____	_____	_____	Yes	No	_____
_____	_____	_____	Yes	No	_____
_____	_____	_____	Yes	No	_____
_____	_____	_____	Yes	No	_____

Please be advised that you may be required to submit medical records.

Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

