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CHILD NEUROLOGY
CONSULTANTS OF AUSTIN

Welcome to the Headache and Migraine Program at Child Neurology Consultants of Austin!

The Headache and Migraine Program team of providers specialize in the diagnosis and management of headaches in children of all ages and provide the most up to date therapies for headache management. We work together to identify potential causes and find an effective way to help children manage their pain.

What to Expect

At your visit you can expect to receive a comprehensive neurological evaluation, followed by an individualized treatment plan that addresses both the treatment of acute headaches and prevention of future headache episodes. Within the program, patients will typically see a combination of their neurologist and the headache program nurse practitioner. If you have any specific questions regarding scheduling and/or follow up visits, please discuss these with your provider.

Headache Program Services

- Headache infusions within our outpatient pediatric infusion centers
- Expedited appointments for patients needing prompt attention
- Headache and migraine injections
    - Botox injections
    - Nerve blocks
    - Sphenopalatine ganglion (SPG) block

Headache and Migraine Program providers include Dr. Riddhiben Patel, Dr. Lindsay Elton, and Madison Gonzales, FNP-C.

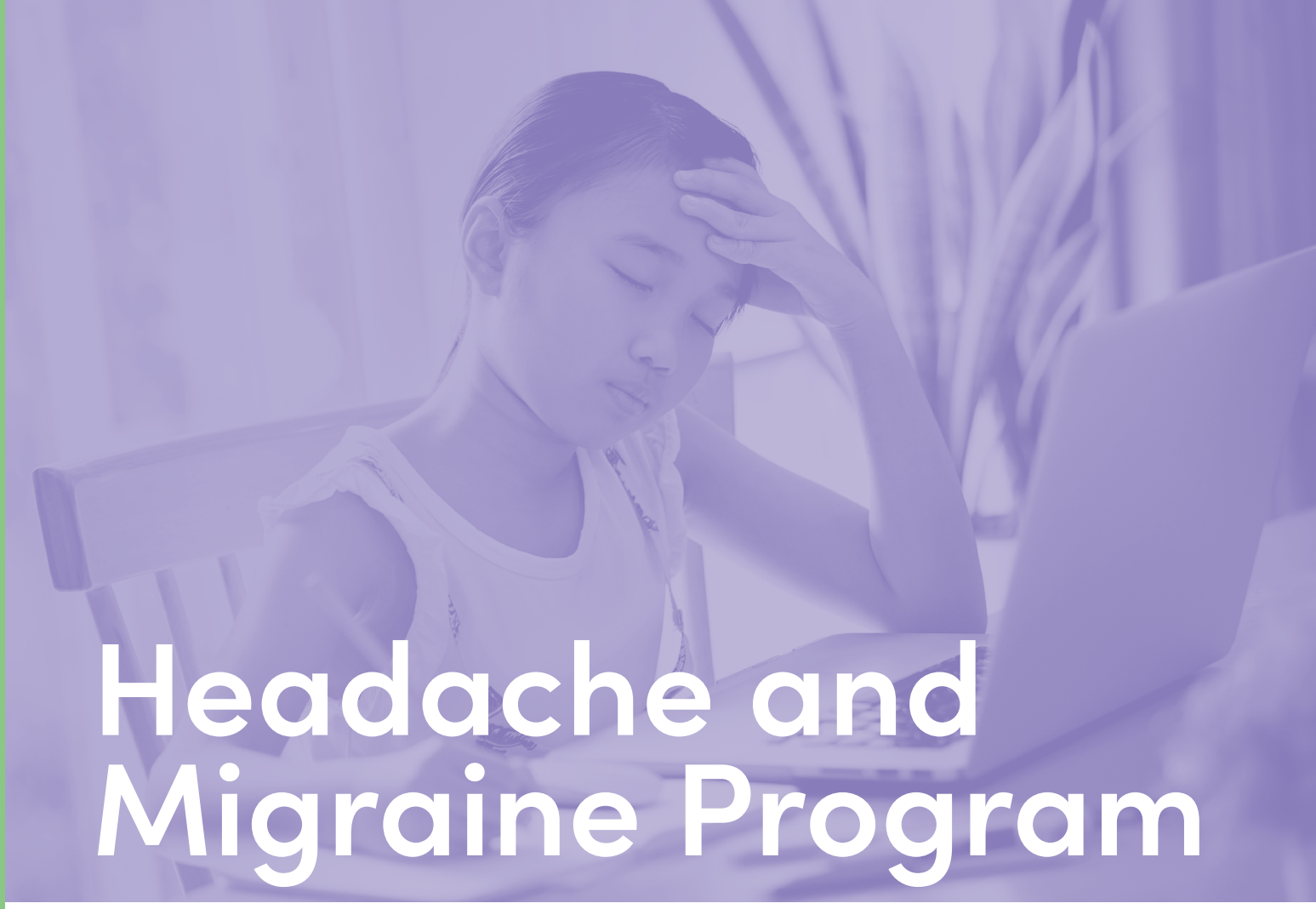
We look forward to working together and can't wait to meet you in person!

CENTRAL AUSTIN CLINIC & PEDIATRIC INFUSION CENTER
7940 Shoal Creek Blvd, Suite 100
Austin, TX 78757
Phone: (512) 494-4000 | Fax: (512) 494-4024

CEDAR PARK CLINIC
1301 Medical Parkway, Suite 300
Cedar Park, TX 78613
Phone: (512) 494-4000 | Fax: (512) 494 4045

SOUTH AUSTIN CLINIC & PEDIATRIC INFUSION CENTER
5301 Davis Lane, Suite 200A
Austin, TX 78749
Phone: (512) 494-4000 | Fax: (512) 494 4090

childneuroTX.com



Headache and Migraine Program

While occasional headaches are common in children, frequent headaches and migraines can be debilitating, interfering with all aspects of life, including quality of sleep, school performance, appetite, and relationships with family and friends. Child Neurology Consultants of Austin's team of pediatric specialists work closely with families to diagnose the child's type of headache and then to develop a plan to effectively manage them.

WHAT SETS US APART

Our team of experts offers the most advanced treatments for effectively managing headaches and migraines. These include prescription medicines and infusions as well as injectable medicines and non-prescription therapies.

With three locations in South Austin, Central Austin, and Cedar Park, including two onsite infusion centers, headache and migraine support is close and convenient.

EXPEDITED HEADACHE APPOINTMENTS

We are available for your child's urgent headache and migraine needs. An expedited appointment should be made if your child is experiencing the following:

- Headaches that last longer than 48 hours despite treatment
- Headaches that have had an abrupt change in frequency
- Headaches that have had an abrupt change in quality or severity

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OUTPATIENT INFUSIONS

The most effective treatment may be infusion therapy for some children and young adults with complex and persistent migraines. Child Neurology Consultants of Austin has two pediatric outpatient infusion centers in its Central Austin and South Austin clinics. Our infusion centers offer a wide range of effective treatments without the need to visit a hospital — a more convenient, cost-effective, and time-effective approach for treating intractable headaches.

HEADACHE AND MIGRAINE INJECTIONS

Botox injections and nerve blocks have been shown to help relieve chronic migraines and headaches. Headache and migraine injections are available onsite at any one of our three locations.

TEAM APPROACH

All of our child neurologists treat headaches and migraines. Children and young adults suffering intractable or hard-to-treat headaches and migraines can be referred to our program to find a long-term solution once and for all. Team members include:

Lindsay Elton, MD
Director of the Headache and Migraine Program

Riddhiben Patel, MD

Madison Gonzales, FNP-C

Our program offers an experienced team that can tailor treatment options for each child. We take a comprehensive approach to care for our patients and work closely with other community providers to address each patient's needs. This may include referring patients to neuropsychiatrists, physical therapists, neuro-ophthalmologists, and other specialists when indicated. Additionally, diagnostic tests such as imaging studies, labs, and lumbar punctures may be obtained as part of the patient's evaluation.

CONTACT US

Contact Child Neurology Consultants of Austin to learn more about our Headache and Migraine Program for children, adolescents, and young adults by calling (512) 494-4000 or booking an appointment online. We look forward to serving you at one of our three convenient locations in Central Austin, Cedar Park, or South Austin.

HEADACHE AND MIGRAINE PROGRAM

INTAKE FORM (INITIAL VISIT)

Child's name: _____ ***Today's date:*** _____

These questions should be completed by the patient. If a parent/guardian is assisting, make sure the responses are the patient's. This information will be used to assist in your care and may be used for study purposes. Please circle all that apply.

Please describe your headaches:

1. **At what AGE did you begin having headaches of ANY type?** _____ years old
2. **Where does your headache occur? (Circle all that apply)**
   Both temples Left temple Right temple Forehead Top of the head Back of the head
   Around eyes (both / left / right) Behind eyes (both / left / right) All over the head
   other_____
3. **What does the pain of the headache feel like?**
   Pounding Throbbing Squeezing Sharp Stabbing Dull Pressure Pinching Burning
   Constant other_____
4. **Are there any auras (warnings) that occur before the headache starts?** YES or NO
   If YES: Changes in vision Changes in taste Changes in smell Numbness Tingling
   Difficulty speaking Weakness in one side of the body other_____
5. **Are there any symptoms BEFORE the headache starts?** YES or NO
   If YES: Yawning Feeling Tired Feeling irritable Sunken Eyes Flushed Face
   Mood Changes Neck pain or stiffness Craving specific foods other_____
6. **What symptoms occur DURING a headache?**
   Nausea Vomiting Sensitivity to light Sensitivity to sound Sensitivity to smells
   Lightheadedness Spinning sensation Red eyes Tearing eyes Runny nose
   Decrease appetite Stomach Fatigue Ringing in the ears Changes in vision Confusion
   Difficulty with thinking or walking or using arms or talking other_____
7. **How long does the headache last?**
   Average: _____ minutes / hours / days
   Longest: _____ minutes / hours / days
8. **On average, how bad would you rate your headaches? (Please choose ONE answer)**
   Mild Moderate Severe
9. **How often does the headache occur?**
   <1 /month 1 to 3 /month 1 /week 2 to 3/week >3 /week
10. **Are there triggers that can start a headache?** YES or NO:
    If YES: Stress Less sleep Skipping meals Hunger Smells
    Light Noises Menstruation Weather School Caffeine
11. **Does activity or playing make the headache worse?** YES or NO
12. **At what percentage are you able to function when you get a headache?**
    100% 75% 50% 25% 0%
13. **What time of the day do your headaches mostly occur?**
    Morning Afternoon Evening Night While asleep

HEADACHE AND MIGRAINE PROGRAM

INTAKE FORM (INITIAL VISIT)

Headache Treatment:

1. **Are you <u>CURRENTLY</u> taking any medications for your headaches?** YES or NO
   If YES, what?_____
2. **Does it work?** YES / NO / MAYBE
3. **Have you taken any medicine in the past for headaches?** YES or NO
   If YES, what? _____
4. **Have you had to go to the emergency room or urgent care for headaches?** YES or NO
   If YES, when was the most recent visit? _____

Headache Disability:

The following questions are to assess how much the headaches are affecting your day-to-day activity. There is not a "right" or "wrong" answer so please put down your best guess.

1. **In the last 3 months, how many full days of school were missed due to headaches? _____**
2. **In the last 3 months, how many partial days of school were missed due to headache? (Do not include the full days you counted in Question #1) _____**
3. **In the last 3 months, how many days did you function less than half your ability in school because of a headache? (Do not include the days counted in Question #1 and #2) _____**
4. **In the last 3 months, how many days were you not able to do things at home due to a headache? (For example: chores, homework, etc.) _____**
5. **In the last 3 months, how many days did you not participate in other activities due to a headache? (For example: play, go out, sports, etc.) _____**
6. **In the last 3 months, how many days did you participate in these activities, but days functioned at less than half your ability? (Do not include the days counted in Question #5) _____**

Healthy Habits:

1. **How much total fluids do you drink per day?** _____ oz. or liters
2. **Do you drink caffeine-containing drinks?** YES or NO
   If YES: How many times per week? _____
3. **Do you skip any meals?** YES or NO
   If YES: How many per week? _____
4. **How many hours of sleep are you getting at night?** _____
5. **Do you do exercise?** YES or NO
   If YES: How many times and how long per week? _____

HEADACHE AND MIGRAINE PROGRAM

INTAKE FORM (INITIAL VISIT)

Other medical conditions and review of systems:

1. Have you ever been diagnosed with any medical or psychiatric conditions?
   Head trauma Brain infections Seizures Strokes ADD/ADHD Asthma
   Seasonal allergies Recurrent sinusitis Depression Anxiety
   other:_____
2. **Have you had a concussion or notable head injury in the past?** YES or NO
   If YES: please explain_____
3. **Have you had any of the following problems?**
   Motion/car sickness Difficulty sleeping Sleep walking Sleep talking Night terrors Snoring
   Repeated episodes of stomach pain/vomiting (without headache) Fainting spells Feeling anxious
   Feeling depressed Shyness Low self-esteem Worrying a lot
   Difficulty at school with: Bullies Homework Grades
4. **Have you had imaging of the head/brain in the past?** YES or NO
   If YES: please explain_____
5. **Do you see any other specialists for any reason?** YES or NO
   If YES: please explain_____

Social history:

1. **What grade level are you currently in at school?** _____
2. **What is your school performance (i.e., grades):** A B C D F
3. **Whom do you live with?** _____

Family history:

1. **Does anyone have a history of migraine headaches in the family?** _____
2. **Does anyone have any other headache type aside from migraine in the family?** YES or NO
   If YES, please explain _____

Menstruation and migraine history: (females only)

1. **Have you had your first menstrual period?** YES or NO
2. **Do you regularly have headaches with your periods?** _____
3. **Are you on birth control?** YES or NO
   If YES: what type? _____

HEADACHE AND MIGRAINE PROGRAM

INTAKE FORM (INITIAL VISIT)

Please draw what it feels like when you get a headache:

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Date:____________________

Name: ____________________________________ Age____________________ Sex:____________________

Category:
M = Migraine
H = Other headache
P = Period (if applicable)

HA score = headache score (**0** = no pain; **10** = the worst pain you have experienced)
Mark an "**X**" for all days you take medication.

Month: ______________________________

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Category																															
HA score																															
Medication																															

Month: ______________________________

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Category																															
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Month: ______________________________

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Category																															
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Month: ______________________________

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Month: ______________________________

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Month: ______________________________

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Category																															
HA score																															
Medication																															

Adapted from the American Headache Society.

Prepared by Dr. Riddhiben Patel, MD

HEADACHE AND MIGRAINE PROGRAM

INTAKE FORM (FOLLOW-UP VISIT)

Child's name: _____ ***Today's date:*** _____

These questions should be completed by the patient. If a parent/guardian is assisting, make sure the responses are the patient's. This information will be used to assist in your care and may be used for study purposes. Please circle all that apply.

Please describe your headaches:

1. **Overall, how would you say your headaches are doing?**
   Better Same Worse
2. **Since the last visit, how would you say your headaches are doing?**
   Better Same Worse
3. **How often does the headache occur?**
   <1 /month 1 to 3 /month 1 /week 2 to 3/week >3 /week
4. **Where does your headache occur? (Circle all that apply):**
   Both temples Left temple Right temple Forehead Top of head Back of head
   Around eyes (both / left / right) Behind eyes(both / left / right) All over the head
   other_____
5. **What does the pain of the headache feel like?**
   Pounding Throbbing Squeezing Sharp Stabbing Dull Pressure Pinching
   Burning Constant other_____
6. **Are there any symptoms BEFORE the headache starts?** YES or NO
   If YES: Yawning Feeling tired Feeling irritable Sunken eyes Flushed face
   Mood changes Neck pain or stiffness Craving specific foods other_____
7. **What symptoms occur DURING a headache?**
   Nausea Vomiting Sensitivity to light Sensitivity to sound Sensitivity to smells
   Lightheadedness Spinning sensation Red eyes Tearing eyes Runny nose
   Decrease appetite Stomach pain Fatigue Ringing in the ears Changes in vision Confusion
   Difficulty with thinking or walking or using arms or talking other_____
8. **How long does the headache last?**
   Average: _____ minutes / hours / days
   Longest: _____ minutes / hours / days
9. **On average, how bad would you rate your headaches? (Please choose ONE answer)**
   Mild Moderate Severe
10. **Since your last visit, how many days of school have you missed because of headaches?**
    _____
11. **Do you have pain over any of the following areas during a headache?**
    Scalp Hair Sinus Neck Arms/Legs

HEADACHE AND MIGRAINE PROGRAM

INTAKE FORM (FOLLOW-UP VISIT)

Headache Treatment:

1. **What medications do you take when you have a headache? (Acute treatment)**
   _____
2. **Does it work?** YES / NO / MAYBE
3. **What medications are you taking to <u>prevent</u> headaches? (Daily treatment)**
   _____
4. **Are you taking any OTHER prescription medications in addition to your headache medication?**
   YES or NO
   If YES, please list it here: _____

Headache Disability:

The following questions are to assess how much the headaches are affecting your day-to-day activity. There is not a "right" or "wrong" answer so please put down your best guess.

1. **In the last 3 months, how many full days of school were missed due to headaches?** _____
2. **In the last 3 months, how many partial days of school were missed due to headache?** (Do not include the full days you counted in Question #1) _____
3. **In the last 3 months, how many days did you function less than half your ability in school because of a headache?** (Do not include the days counted in Question #1 and #2) _____
4. **In the last 3 months, how many days were you not able to do things at home due to a headache?** (For example: chores, homework, etc.) _____
5. **In the last 3 months, how many days did you not participate in other activities due to a headache?** (For example: play, go out, sports, etc.) _____
6. **In the last 3 months, how many days did you participate in these activities, but days functioned at less than half your ability?** (Do not include the days counted in Question #5) _____

Healthy Habits:

1. **How much total fluids do you drink per day?** _____ oz. or liters
2. **Do you drink caffeine-containing drinks?** YES or NO
   If YES: How many times per week? _____
3. **Do you skip any meals?** YES or NO
   If YES: How many per week? _____
4. **How many hours of sleep are you getting at night?** _____hours
5. **Do you do exercise?** YES or NO
   If YES: How many times and how long per week? _____

Social history:

1. **What grade level are you currently in at school?** _____
2. **What is your school performance (i.e., grades):** A B C D F
3. **Whom do you live with?** _____