



CMH Neurology and Headache Center
1245 N. Butterfield Road, Suite C1, Bolivar • 417-327-3530

Migraine Research Questionnaire

Name _____ Age _____ DOB _____

Address _____ City _____

Phone Number _____ Today's Date _____

Do I have your permission to proceed and ask you a few questions to help determine if we have a study for you? ☐ Yes ☐ No

1. How long have you had headaches/ migraines?

2. In the last 3 months, how many days per month do you experience any kind of a headache? _____ Days

3. The following are symptoms that may occur during a migraine headache. When describing your moderate - severe headaches/migraine headaches, please answer the following:

a. Length of your migraine attacks: ☐ 0 – 3 hours ☐ 4 hours or longer

b. Location of pain: ☐ Unilateral (one-side of head) ☐ Bilateral (both sides of head)

c. Is the pain throbbing and/or pulsating? ☐ Yes ☐ No

d. Is it aggravated by physical activity like walking or climbing stairs? ☐ Yes ☐ No

e. Do you experience nausea and/or vomiting? ☐ Yes ☐ No

f. Do you have light and sound sensitivity? ☐ Yes ☐ No

4. In the last 3 months, how many days per month do you experience a migraine (as described above)? _____ Days

5. What medications do you use to treat your headaches and/or migraines?

6. Has your headaches/migraines ever caused you to miss work? ☐ Yes ☐ No

a. If yes, approximately how many hours you miss per month? _____ hrs.

7. Other Medical Conditions/ Diagnosis:

Migraine Research Questionnaire cont.

8. Other Medication that you take: _____

9. Do you use any CBD oils, medicinal marijuana use, or any other recreational drugs? ☐ Yes ☐ No

10. Do you have a history of suicide attempts? ☐ Yes ☐ No

11. Are we able to keep this information on file for possible qualifications in a future research study?

☐ Yes ☐ No (Information will be destroyed at the conclusion of the call)

This information will be reviewed to determine if we have a current research study for you to participate in. After this review is completed, we will call and/or email you to inform about the next steps. Thank you!

Clinical Research Staff to complete:

☐ Eligible for a study at this time: _____

Complete a study specific – IRB approved phone screening script – completed on: _____

☐ Not eligible for a study at this time;

Contacted patient on _____ to inform them of ineligibility

Notes:
