Emergency Room Treatment Form

I am experiencing a severe migraine headache attack. I am not a substance abuser or "drug seeker." Below, I have provided information about my current migraine episode, my current and prescribed treatments and my medical insurance information. My physician also filled out a form verifying my diagnosis and outlining my treatment(s).

Patient Information

Name ______________________________ Date of Birth ______________

Address ______________________________

City ______________ State ______________ Zip ______________

Home phone ______________ Office Phone ______________

Insurance carrier ______________________________

Insurance policy number ______________________________

Other info ______________________________

Employer ______________________________

Emergency contact ______________________________

Relationship ______________________ Phone ______________

Patient Treatment Information

I am experiencing the following symptoms (circle those that apply):

Extreme head pain Nausea Light sensitivity Sound sensitivity

Others ______________________________

On a scale of 1-10, I currently rate my pain at ______________.

I have taken the following medication(s) for my current migraine attack:

Medication	Dose	Time taken
Medication	Dose	Time taken
Medication	Dose	Time taken

Other Patient Information

Other non-migraine medications ______________________________

____

Supplements or vitamins ______________________________

____

Over-the-counter medications

____

Medication allergies ______________________________

____

Other medical conditions

____

____

Signature ______________________ Date ______________

This form was created by National Headache Foundation. Copyright 2003.

820 N. Orleans, Suite 217, Chicago, IL 60610-3132 Toll Free (888) NHF-5552 Fax (312) 640-9049 www.headaches.org