<u>**Seacoast Neurofeedback, LLC**</u>

Name: ______________________________________

Date: _____/_____/_________

Migraine:

1. **When did they start? Age of onset:**

2. **Location of pain:**

3. **Frequency:**

4. **Severity on a scale of 1-10 with 10 being the worst:**

5. **Duration:**

6. **Light Sensitivity:**

7. Nausea:

8. Do you experience an aura?: Yes _______ No _______

a. Visual:

b. Other:

8. Do you know your triggers?: (diet; weather changes; rain; hormones or menses, etc.)

9. History of anxiety _______ depression _______
a. medication:

b. alternative treatments: