

Emergency Treatment Information:

I am experiencing extreme head pain resulting from a Cluster Headache attack. I am not a "drug seeker," and have brought a form from my doctor verifying my diagnosis and treatment information.

Registration Information:

Full Name

Address

City

State

Zip Code

Home Phone

Office Phone

Employer

Emergency Contact

Relationship

Phone Number

Treatment Information:

Duration: This attack began: _____

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

To treat this Cluster Headache attack, I have taken these medications:

Medication

Dosage

Time Taken

Medication

Dosage

Time Taken

Medication

Dosage

Time Taken

Other Medications:

Medication

Dosage

Condition

Medication

Dosage

Condition

Medication

Dosage

Condition

Medication

Dosage

Condition

Medication

Dosage

Condition

Known Allergies: _____

Signature

Date