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**Supplement to ConnectiCare® SOLO Application**  
**HEADACHE QUESTIONNAIRE**

Name of primary applicant: \_\_\_\_\_ . ID/SSN: \_\_\_\_\_ .

Name of person related to condition: \_\_\_\_\_ .

1. Date of diagnosis or first symptoms: \_\_\_\_\_ .
2. Frequency of headaches:  
Number per week: \_\_\_\_\_ .  
Number per month: \_\_\_\_\_ .  
How long do they last? \_\_\_\_\_ .
3. Are your headaches mild, moderate or severe? \_\_\_\_\_ . Date of your last headache? \_\_\_\_\_ .
4. Have you lost any time from work or been told to restrict any activities? Yes or No: \_\_\_\_\_ . If yes, please provide details:  
\_\_\_\_\_ .
5. Are you taking medication for this condition? Yes or No: \_\_\_\_\_ . If yes, please provide the name of medication, dosage, and the frequency with which you take it:  
\_\_\_\_\_ .
6. How often do you see the doctor for this condition? \_\_\_\_\_ .  
Has he/she advised you to have any further testing or surgeries? Yes or No: \_\_\_\_\_ . If yes, please explain: \_\_\_\_\_ .
7. Please provide the name, date, and results of any special test/studies done (MRI, CT Scan, etc.):  

<b>Name of test/study:</b>	<b>Date of test/study &amp; Results:</b>
_____	_____
_____	_____
_____	_____
8. Are the headaches caused by an eyestrain, sinus infection, hypertension, brain tumor, aneurysm, trauma, acute febrile illness or temporal arteritis? Yes or No: \_\_\_\_\_ . If yes, please provide details:  
\_\_\_\_\_ .
9. Please provide the name and address of the most current treating physician for this condition:  
\_\_\_\_\_ .

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (or parent / guardian if under 18): \_\_\_\_\_ .

Today's date: \_\_\_\_\_ .