

Please indicate as appropriate.  
 Write dates in this format dd/mm/yyyy

Previous Botox injections as a chronic migraine patient (Recommended re-treatment is every 12 weeks) <i>circle</i>	Yes	No	<i>If yes what was date of last injection: dd/mm/yyyy</i>
Number of previous treatments	<i>(When determining number of headache days, it may be beneficial to ask the patient how many headache-free days each month the patient is experiencing)</i>		
Number of total headache days within 3 months (current score)	Baseline prior to Botox		
Number of total migraine days within 3 months (current score)	Baseline prior to Botox		

Pain location <i>circle</i>		Temporalis	Occipitalis	Trapezius
Predominant, usual pain location and/or muscle tenderness upon palpation <i>tick all that are applicable</i>	Left Side			
	Right Side			

Injection procedure record	
Dilution:	4mL of preservative-free 0.9% saline per 200 units of Botox.
Needle:	30-gauge, half inch.
Administration:	Inject 0.1mL (5 units) intramuscularly at each injection site.

Injection sites: Number of Units (U) per muscle (number of injection sites)				
Head/Neck area	Fixed-Site, Fixed Dose		Follow-the-pain	
		<i>Tick when completed</i>	Left	Right
Corrugator	10 U (5U each side)			
Procerus	5 U			
Frontalis	20 U (10 U each side)			
Temporalis	40 U (20 U each side)		10 U (≤2 sites)	_____ U
Occipitalis	30 U (15 U each side)		10 U (≤2 sites)	_____ U
Cervical Paraspinals	20 U (10 U each side)			
Trapezius	30 U (15 U each side)		20 U (≤4 sites)	_____ U
<b>Total</b>	155 U		_____ U	_____ U
<b>Total Dose: Fixed-Site, Fixed-Dose + Follow-the-Pain</b>			<b>195 U (155-195 U)</b>	
<b>Headaches on ≥15 days per month, of which at least 8 days are with migraine</b>				

Injector signature:		Injector print name:	
Designation:		Date: dd/mm/yyyy)	

**Neurology Department**  
**BOTOX (Botulinum toxin type A) Injection Record for Chronic Migraine Patients**

<b>Post Injection Follow-Up</b>	
Overall patient response to Botox (Botulinum toxin type A) treatment	
Adverse Events (Botox treatments)	
HIT - 6 Score	

<b>Overall patient response to other treatments and / or medications</b> <i>(if applicable):</i>	
Acute	
Preventatives (Old)	

<b>Management Plan</b> <i>(if applicable):</i>	
Follow-up	
Changes to medication	

Injector signature:		Injector print name:	
Designation:		Date: <i>(dd/mm/yyyy)</i>	