Headache Questionnaire (page 1 of 3)

Name: __________________________ SS#: __________________________ Date: ____________

Address: __________________________________________ Occupation: ________________

Phone(Home): ___________ (Work): ___________ Date of Birth: ___________ Age: ________

Date of Birth: ___________________________ Referred by: __________________________

Medical History

Please check or fill in the correct answer to each of the following that apply:

At what age did your headaches begin? ____________________________________________

Does anyone else in your immediate family have headaches? □ Yes □ No

If yes, please specify: ___________________________________________________________

Number of headache days / month__________ Current __________ Baseline ____________

Number of headache hours / day ____________ Current __________ Baseline ____________

How would you rate the physical discomfort you experienced?

□ Very mild  □ Mild  □ Uncomfortable, but not painful  □ Painful  □ Extremely Painful

Do your headaches result in lost time at work or your normal daily activities?

□ Yes  □ No  □ Sometimes

Symptoms

Which of the following do you associate with a typical headache?

□ Dull, no throbbing pain  □ Pain on one side of head

□ Pain that lasts for days at a time  □ Throbbing, pulsating pain

□ Pain on both sides of head  □ Nausea

□ Tightening of muscles in head, face and neck  □ Vomiting

□ Sensitivity to light
Headache Questionnaire (page 2 of 3)

Name: ___________________________________________ Date: _______________

☐ Daily headaches ☐ Sensitivity to sound
☐ Pain occurring at night ☐ Nasal drainage
☐ Intense pain behind or around one eye ☐ Tearing
☐ Pain that causes awakening from sleep ☐ Eyelid drooping
☐ Dizziness ☐ Nasal congestion

Triggers
Of the following, which seems to bring on a headache?

☐ Menstruation ☐ Alcohol
☐ Exercise ☐ Bright light or glare
☐ Stress ☐ Certain odors
☐ Smoking ☐ Excessive noise
☐ Relaxation after stress ☐ Too much sleep
☐ Change in weather ☐ Food additives (MSG, etc.)
☐ Certain foods ☐ Medications
☐ Hunger ☐ Too little sleep
☐ Change in sleeping habits ☐ Other

Have you experienced warning signs of oncoming headaches? Yes ☐ No ☐
Headache Questionnaire (page 3 of 3)

Name: _________________________________ Date: ______________

Treatment Medication
Do any of the following relieve your headache pain?

<table>
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<tr>
<th>Current previous drug name(s) Therapy</th>
<th>Currently taking (Y / N)</th>
<th>Duration of trial</th>
<th>Results (effectiveness, tolerability, etc)</th>
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Which over-the-counter medications have you taken for headaches (Examples: Aspirin, Acetaminophen, Ibuprofen)?

____________________________________________________________________________

How many OTC pills do you take a day? □ 1 - 2 □ 3 - 4 □ 5+

Comments: ____________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________