Center for Neurological Treatment & Research
NEUROLOGICAL AND SLEEP DISORDER

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 ☐ Painfull ☐ 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 that lasts for days at a time

☐ Pain on both sides of head

☐ Tightening of muscles in head, face and neck

☐ Sensitivity to light

☐ Pain on one side of head

☐ Throbbing, pulsating pain

☐ Nausea

☐ Vomiting

Headache Questionnaire (page 2 of 3)

Name: _____ Date: _____

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

Triggers

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

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

Current previous drug name(s) Therapy	Currently taking (Y / N)	Duration of trial	Results (effectiveness, tolerability, etc)

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: _____

_____

_____

_____