New Visit Headache Questionnaire

Please answer the following questions to the best of your ability

Last Name: _____ **First Name:** _____

Date of Birth: _____ **Date of visit:** _____

ONSET:* At what age did you begin having headaches of ANY type? _____ Years old

Family History of Headaches? * Yes No

FREQUENCY:* How often do the headaches occur? <1 /month 1 - 3 /month 1/week 2 - 3 /week >3 /week Daily Always

DURATION:* On average how long do headaches usually last? <1 hr. 1-2 hrs. 2-4 hrs. 4-6 hrs. >6 hrs.

SEVERITY:* On a scale of 0 to 10, what is the severity of your headache? (0 = no pain; 5 = moderate pain; 10 = worst pain)

Circle best answer: 1 2 3 4 5 6 7 8 9 10

Has the frequency, duration or severity of the headaches changed? Yes No **If yes, how?** _____

TIMING: Does the headache occur at a particular time of the day? Yes No

Waking up Morning Afternoon Evening Night Other _____

Has your headache ever woken you up from a sound sleep due to pain?* Yes No

LOCATION:* Where does your headache hurt?

Both sides Left side Right side Front Top Back Around eyes Behind eyes All over

DESCRIPTION:* Describe your headache pain?

Throbbing Squeezing Stabbing Pinching Pressure Burning Sharp Constant Dull Other _____

AURAS:* Are there any warnings (auras) that the headache is going to start? Yes No

Vision Changes (loss of vision, blurry vision, spots/floaters, tunnel vision, etc.) Taste Trouble talking

Sensory (numbness, tingling, pins and needles) Weakness on one side of body Other _____

ASSOCIATED SYMPTOMS: What symptoms occur with your headache?

Nausea Vomiting Sensitivity to light Sensitivity to sound Sensitivity to smells Spinning sensation Changes in vision Tearing eyes

Runny nose Ringing in the ears Confusion Stomach pain Other _____

TRIGGERS:* Are there triggers that can start a headache? Yes No

Sleep – too little / too much Inadequate hydration Hunger / Skipping meals Stress Weather Menstruation

Food / Chocolate / Caffeine Light Noises Smells School Concentration Other _____

Are your headaches primarily only with exercise?* Yes No

Headache Treatment:

What medications are you CURRENTLY taking for your headaches? _____

How many days a week do you use these medications to TREAT your headaches? _____ days/week

Medications you are taking to PREVENT headaches: _____

Vitamins or health foods for headaches: _____

Headache Disability: These questions assess how much headaches are affecting your day-to-day activity. Please answer based on ALL headaches you have had in the **last TWO months**

How many days of school were missed due to headaches? None 1-5 6-10 10-15 >15

How many days were you unable to participate in activities (play, go out, sports) due to headaches? None 1-5 6-10 10-15 >15

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Office Use Only:

Abortive Therapy: NSAID Triptan None Other _____

Preventative Therapy: Nutraceutical CBT None Other _____

Discontinue Medication Overuse: Yes No N/A