Follow Up Headache Questionnaire

Please answer the following questions to the best of your ability

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

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

UPDATE: Is your headache since the last visit : Better Same Worse

FREQUENCY: How often do the headaches occur now?

<1 /month 1 to 3 /month 1 /week 2 to 3 /week >3 /week Daily Always

DURATION: If you do not treat your headaches, 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 |

How many days per month did you have ANY headaches (small or big)? _____days per month

Headache Treatment:

Do you feel the medication to stop the headache is working if you take it as soon as the headache starts: Yes No

Headache Disability (in the past 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:

Improvement in Frequency: Yes No Same

Improvement in Duration: Yes No Same

Improvement in Headache Disability: Yes No Same