Headache Questionnaire

Patient's Name: _____ **Date:** _____

1. Did the headaches start after an accident, illness or infection?

2. How long has the patient had these headaches?

3. Are the headaches constant or do they come and go?

4. How often do the headaches occur? (daily, weekly, monthly)

5. Do the headaches occur at a certain time of the day? _____morning _____afternoon _____night

6. Are the headaches becoming stronger, lasting longer or occurring more frequently?

7. Do the headaches ever wake up the patient up when he is sleeping?

8. Does rest or sleep relieve the headache?

9. Do the headaches stop the patient from doing things? (like playing, watching TV, going outside or doing homework.)

10. Has the patient ever missed school or work because of a headache?

11. Is the headache pain intense when it starts, or does it start out small and builds up?

12. Please check all of the things that **bring on the headaches:**

_____Odors (Perfume, cigarettes)	_____Fatigue	_____School
_____Hunger (missing meals)	_____Loud noises	_____Anxiety or stress
_____Exercise or playing	_____Ice Cream	_____Family problems
_____Too much sleep (sleeping in)	_____Bright Lights	_____Menstrual cycles
_____Too little sleep (staying up late)	_____Sunshine	_____Birth Control Pills
_____Riding in a car	_____Hot weather	_____Alcohol (wine, beer)

_____Medications Which ones? _____

_____Certain foods Which ones? _____
(for example: chocolate, peanut butter, eggs, milk, pizza, etc.)

13. Are nasal congestion, sinusitis or allergies associated with the headache?

14. Are there any warning signs BEFORE the headache begins?

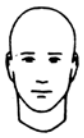
_____Paleness	_____Mood swings (either high or low)	_____Irritability
_____Dizziness	_____Tired, sleepy, or yawning	_____Increased appetite
_____Rings around the eyes	_____Hyperactivity	_____Craving sweets

_____Eye problems (like blurred vision, black spots, flashing lights, or double vision)

15. Where is the headache located?

_____Left side _____Forehead _____All around the head
_____Right side _____Temples _____Top of the head
_____Neck _____Back of the head

If the pain is another part of the head please describe or mark the location:


16. What does the pain feel like?

_____Throbbing or pounding (like a hammer) _____Exploding _____Sharp
_____Tightness (like a rubber band wrapped around the head)
_____Dull _____Aching _____Pressure

Please describe the pain in your own words:

17. Are there any other symptoms when the patient has a headache?

_____Nausea _____Stomach pains _____Weakness in the arms or legs
_____Vomiting _____Confusion _____ Numbness in the arms or legs

If there are any other symptoms, please describe them:

18. Who else in the family has had headaches, migraines, sick headaches, motion sickness, "brain freeze" from eating ice cream or had trouble taking Birth Control Pills because of headaches?

19. Describe any stresses in the last year (such as separation, divorce, job changes, moves, death in the family, or poor grades).

20. Who has treated the patient for headaches? When were they treated?

What tests were done?

_____CT scan _____Eye Exam _____Sinus X-rays
_____MRI _____Dental exam _____Allergy Tests
_____Spinal Tap _____Allergy tests ____Blood tests etc.)
Any other tests?:

21. What medications or treatments have you tried? (glasses, allergy shots, chiropractor, **herbal medicines**, Motrin, Tylenol, prescription medicines, etc.)

23. What questions do you have about the patient's headaches? What worries you the most? What medical tests, medicines or therapies do you what to know about?