headache questionnaire

Patient’s Name: __________________________________________________    Date: _______________
Date of Birth: _____________________________

1. How long have you had headaches that interfere with school, sports, activities, etc.?
______________________________________________________________________________

2. Did the headaches start after an accident, illness or infection?   Yes   No
How old were you when the headaches started? _____________________________

3. Did the headaches begin or worsen after an injury or concussion?   Yes   No
If so, when? ___________________________________________

4. How would you describe the quality of the pain?
   ____ Sharp     ____ Dull     ____ Throbbing     ____ Other

5. How often do the headaches occur?
   ____ Daily     ____ Weekly     ____ Monthly     ____ Other

6. Do the headaches occur at a certain time of the day?   Yes   No
   ____ Morning     ____ Afternoon     ____ Night

7. How long do the headaches last?
   ____ Minutes     ____ Hours     ____ Days     ____ Weeks     ____ Continuous

8. Where on your head do the headaches hurt?
   ____ Front     ____ Back     ____ Neck     ____ Right     ____ Left     ____ Everywhere

   Do they start at one place then move to another?   Yes   No   ________ to _________

9. How would you describe the severity of the pain?
   ____ Mild     ____ Moderate     ____ Severe     ____ Incapacitating

10. Do the headaches ever wake you from sleep?   Yes   No

11. Does anything help the headaches when you get them?
    ____ Dark, quiet room     ____ Medications     ____ Sleep     ____ Others
12. Is the headache pain intense when it starts, or does it start mild and worsen?

______________________________________________________________________________

13. What medications have been used to stop a headache, or keep it from getting worse?
   Over the counter: _______________________________________________________________
   Prescription: ___________________________________________________________________

14. If any of the above medications were stopped, please indicate why (not helpful, side effects, both, etc.):
   ______________________________________________________________________________
   ______________________________________________________________________________

15. What medications have been used on a daily basis to prevent headaches?
   Over the counter: _______________________________________________________________
   Prescription: ___________________________________________________________________

16. If any of the above medications were stopped, please indicate why (not helpful, side effects, both, etc.):
   ______________________________________________________________________________
   ______________________________________________________________________________

17. Are you currently using any of the above medications?  Yes  No
   If so, please circle them.

18. Alternative treatments used to treat/prevent headaches?
   Vitamins ___________________________________________ Helpful?  Yes  No
   Herbals ___________________________________________  Helpful?  Yes  No
   Chiropractor ______________________________________  Helpful?  Yes  No
   Massage __________________________________________  Helpful?  Yes  No
   Others ____________________________________________  Helpful?  Yes  No

19. Have you been to an Emergency Room because of headaches?  Yes  No
   More than once?  Yes  No
   If so, where and when?
   ______________________________________________________________________________
   ______________________________________________________________________________

20. Are you currently in school?  Yes  No
   Grade ____  Regular ____  IEP ____  504 ____
   Current concerns: ____Academic  ____ Social  ____ Behavioral

21. Have you ever missed school because of a headache?  Yes  No
   If yes, how many days on average?  ____ days/week  ____ days/month  ____ days/year

22. Is there any previous/current history of emotional/mood problems?  Yes  No
   Anxiety/Worry  Yes  No
   Sadness/Depression  Yes  No
   Behavioral  Yes  No
23. Is there any previous/current history of mental health services?   Yes  No

24. If yes, please specify when, where, and the reason for treatment:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

25. Have your headaches had an effect on appetite?   Yes  No
  ___ Decrease in appetite  ___ Increase in appetite

26. Has your pain affected/limited your ability to focus or concentrate?  
   Yes  No

27. Have you experienced any recent changes or stressors?  Yes  No
If yes, please specify:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

28. Please check all the things that bring on or worsen your headaches
  ___ Odors (perfumes, cigarettes, etc.)  ___ Fatigue  ___ Trauma to head
  ___ Hunger (missing meals)  ___ Loud Noises  ___ School
  ___ Exercise or playing  ___ Ice Cream  ___ Anxiety or Stress
  ___ Too much sleep (sleeping in)  ___ Bright lights  ___ Family problems
  ___ Too little sleep (staying up late)  ___ Sunshine  ___ Menstrual Cycles
  ___ Riding in a car  ___ Weather Changes  ___ Birth Control Pills
  ___ Alcohol (wine/beer)  ___ Certain foods  Which ones?____________________________________
  (for example: chocolate, peanut butter, eggs, milk, pizza, etc.)

29. Are there any warning signs BEFORE the headache begins?
  ___ Paleness  ___ Mood swings (either high or low)  ___ Irritability
  ___ Dizziness  ___ Tired, sleepy, yawning  ___ Hyperactivity
  ___ Craving Sweets  ___ Rings around the eyes  ___ Trouble thinking/speaking
  ___ Increased/decreased appetite
  ___ Eye problems (blurred vision, black spots, flashing lights or double vision)

30. Are there other symptoms that occur with the headaches?
  ___ Body numbness  ___ Body weakness  ___ Dizziness
  ___ Nausea/Vomiting  ___ Light/Noise sensitivity  ___ Confusion
  ___ Trouble thinking or speaking

31. Does anything make the pain less, shorter?  Yes  No
What? ____________________________________________
32. Do you have any current, chronic pain in any other body regions?
   ____ Neck    ____ Back    ____ Arms/Legs    ____ Abdomen    ____ Chest    ____ Other

33. How many hours of sleep do you get each night? __________
   Problems falling asleep?  Yes  No
   Problems staying asleep?  Yes  No
   Always fatigued/no energy?  Yes  No

34. Do you drink fluids with caffeine (pop, tea, coffee)?  Yes  No
   If yes, how often?
   ____ daily    ____ almost every day    ____ 1-2/week    ____ less

35. Has any testing been done?  ____ CT Scan  ____ MRI  ____ EEG  ____ Others
   If yes, please bring copies of the results, films if available, to your appointment.

36. Previous history of seizure/epilepsy?  Yes  No
   Current/previous medications:
   __________________________________________________________________________
   __________________________________________________________________________

37. Does anyone on either side of the family have (or have a history of) significant headaches?

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<thead>
<tr>
<th></th>
<th>Sinus/Allergy</th>
<th>Migraine</th>
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<tbody>
<tr>
<td>Biological Mother</td>
<td>Yes  No</td>
<td>Yes  No</td>
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<tr>
<td>Biological Father</td>
<td>Yes  No</td>
<td>Yes  No</td>
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<tr>
<td>Biological Sister(s)</td>
<td>Yes  No</td>
<td>Yes  No</td>
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<td>Biological Brother(s)</td>
<td>Yes  No</td>
<td>Yes  No</td>
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<td>Others</td>
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38. Please add any other significant information we may have missed.  Thank you.
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
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   __________________________________________________________________________
Pain Coping Questionnaire: Pain Coping Efficacy

When you are hurt or in pain for a few hours or a few days, how often do you think you can do something to change it?

___ Never (1)   ___ Hardly Ever (2)   ___ Sometimes (3)   ___ Often (4)   ___ Very Often (5)

Being hurt or in pain can be hard or easy to deal with. How hard or easy is it for you to deal with being in pain?

____ Really Easy (5)     ____ Kind of Easy (4)     ____ Kind of Easy/Kind of Hard (3)
____ Kind of Hard (2)  ____ Really Hard (1)

How often do you think you can do something to change your moods or feeling when you are hurt or in pain?

___ Never (1)    ___ Hardly Ever (2)    ___ Sometimes (3)    ___ Often (4)    ___ Very Often (5)

Please bring this questionnaire filled out and completed with you to your first appointment.