HEADACHE QUESTIONNAIRE

I. General Date_____

Name_____

Address_____

City/State/Zip_____

Phone: Home_____ Work_____

Age_____ Sex_____ Height_____ Weight_____

Race_____ Place of Birth_____

II. Headache Profile

Please note: if you have more than one type of headache, use an extra headache profile for each type.

A. Onset of headaches:

Length of time you have been having headaches:_____

How old were you when your headaches began?_____

What age did you reach puberty?_____

Is there any particular inciting event when the headaches started which you feel may have helped to cause your headaches?_____

_____

Have you ever suffered an injury to the head, neck, or face?

When_____ Area affected_____

Loss of consciousness_____How long?_____

Circumstances_____

Litigation pending?_____

B. What is the frequency of headaches in the past year? _____

What was the frequency prior to the past year?_____

Does your headache occur any special:

Time of day_____ Day of week_____

Time of month_____Time of year_____

No, it occurs anytime at all_____

Average duration of each headache:

Treated_____

Untreated_____

Are you awakened by headache at night? _____ How often?_____

Are your headaches getting: Worse / Same / Better

Are you ever free of pain? _____ When?_____

C. Location of pain:

Forehead_____ Right / Left / Both

Temple_____ Right / Left / Both

Side of head_____ Right / Left / Both

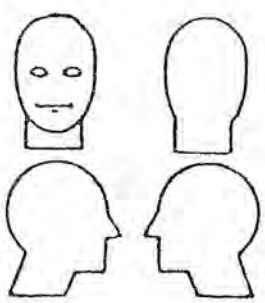
Back of head_____ Top of head_____

Whole head_____ Hatband_____

Neck_____ Face_____

Where does your pain start?_____

Does the pain migrate around?_____



D. Quality of pain: (circle)
Throbbing / Steady / Pressure / Squeezing / Stabbing / Shocklike / Sharp / Dull Ache / Burning
Deep or superficial? (circle)

E. Severity of pain:
Rate the severity of your headache pain:
On Average: Mild 1---2---3---4---5---6---7---8---9---10 Severe
Maximum: Mild 1---2---3---4---5---6---7---8---9---10 Severe

How long does the headache take from the first inkling of pain to maximum severity? _____

Does the pain usually prevent normal activities? _____
If so, please explain _____

How often do you have to leave work/school because of the headache?
_____

F. Associated symptoms: Check the appropriate column only if you get any of the following WITH a headache:

	Before	During	After
Visual blurring			
Blind spots			
Flashing lights			
Halos around lights			
Sensitivity to light			
Sensitivity to noise			
Numbness: face/arm/leg			
Tingling: face/arm/leg			
Weakness: face/arm/leg			
Dizziness			
Unsteadiness			
Spinning			
Trouble Concentrating			
Severe Confusion			
Inability to speak			
Fainting			
Nausea			
Vomiting			
Diarrhea			
Nasal congestion			
"Runny" nose			
Tearing			
Redness of eye(s)			
Drooping eyelid(s)			
Neck stiffness/soreness			
Fluid retention			
Flushed face/head			

G. Triggers: Do any of the below cause or exacerbate a headache? (circle)

Stress / Anger / Anxiety _____
Heat / Cold _____
Hunger / Chewing / Yawning _____
Lack of sleep / Too much sleep _____
Weather changes / Air flights _____
Smoke / Aromas / Perfume _____
Alcohol / Certain foods _____
Menstruation / Ovulation / Pregnancy _____
Position / Head movements _____
Glare / Flickering lights _____
Exercise / Relaxation _____
Do you think any of your medications exacerbate it? _____
Other _____

H. Relief of pain:

Have you tried any of the following?: Please rate its effectiveness.

	Not Effective	Mod. Effective	Very Effective
Bedrest/Sleep	_____	_____	_____
Darkness	_____	_____	_____
Quiet	_____	_____	_____
Local Heat	_____	_____	_____
Cold/Ice pack	_____	_____	_____
Massage	_____	_____	_____
Increased activity	_____	_____	_____
Bath or Shower	_____	_____	_____
Tea/Coffee	_____	_____	_____
Alcohol	_____	_____	_____

Do you feel that nothing helps? _____

I. Headache medication profile

Please list all medications which you have tried for headache:

Drug	Dosage	Length of Time Taken	Effectiveness	Side Effect
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

J. Other therapies tried: Date: Effectiveness:

		None	Moderate	Very
Biofeedback	_____	____	____	____
Relaxation Techniques	_____	____	____	____
Psych. counseling	_____	____	____	____
TENS unit	_____	____	____	____
Acupuncture	_____	____	____	____
Trigger point injection	_____	____	____	____
Cervical collar	_____	____	____	____
Cervical pillow	_____	____	____	____
Traction	_____	____	____	____
Sinus drainage	_____	____	____	____
Surgery	_____	____	____	____

K. Diagnostic tests done in the past:

Procedure:	Date:	Results:
Neck X-ray	_____	_____
Skull X-ray	_____	_____
Sinus X-ray	_____	_____
Cat Scan of head	_____	_____
MRI of head	_____	_____
EEG (brain wave)	_____	_____
Blood tests	_____	_____
Other tests	_____	_____

L. What doctors have treated you for your pain symptoms?

Physician:	City/State:	Specialty:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

M. Family History:
Mother: Headaches? _____
Other medical conditions? _____
Father: Headaches? _____
Other medical conditions? _____
Other _____

N. Childhood history:
Headaches _____ Motion (car) sickness _____
Other _____

III. Past medical history
Do you or have you ever had any of the following?
special problems with eyes _____
special problems with ears _____
special problems with teeth _____

TMJ	_____	hypoglycemia	_____
hypertension	_____	diabetes	_____
heart attack	_____	sinusitis	_____
cardiac pain	_____	heart failure	_____
asthma	_____	emphysema	_____
thyroid	_____	liver disease	_____
cancer	_____	psychiatric	_____
stroke	_____	seizure	_____

other _____

IV. Past surgical history

coronary bypass_____
carotid endarterectomy_____
craniotomy (open head)_____
neck or back surgery_____
hysterectomy_____
other_____

V. Current medications

Please list all medications you are currently taking:
(include birth control pills and over-the-counter drugs)

Name	Dose

VI. Medication allergies/reactions

Names	Reaction

VII. Toxins: Have you been exposed to: (circle)

Chemicals / Fumes / Pesticides / Arsenic / Lead / Mercury / harmful irradiation / Other_____

VIII. Review of Systems

Have you recently or chronically had the following symptoms UNRELATED to your headaches?: (please circle)

Weight loss / gain: # pounds_____ Over how long?_____

Fever/Chills	Cold hands/feet
Chest pain	Abdominal pain
Chest tightness	Diarrhea/Constipation
Palpitations in chest	Increased heart rate
Heat/cold intolerance	Nervousness
Dizziness	Light headedness
Memory difficulties	Visual difficulties
Problems speaking	Depressed mood
Numbness of an extremity	Weakness of an extremity
Gait disturbance	Balance problems
Neckaches/neck tightness	Fatigue
Jaw pain: Right / Left	Face pain: Where?_____
Clicking of jaw joint	Difficulty opening/closing jaw
Ringing in ear: Right / Left	Fullness in ears/sinuses

Please rate your general health: Excellent / Good / Fair / Poor

IX. Habits/Lifestyle

Diet: No. meals per day: 1 - 2 - 3 - 4 - 5 - 6

Food allergies/intolerances_____

Cups of coffee/tea/"Cokes" per day: 1-2 / 3-5 / 6-10 / >10

(Please do not include decaffeinated beverages)

Do you eat:	Does it give you a headache?
___Chocolate	_____
___Cheese	_____
___Chinese food	_____
___Red wine	_____

Alcohol consumption - beer / wine / liquor:

No. drinks per day: 0 / 1-6 / 7-12 / More
No. drinks per week: 0 / 1-6 / 7-12 / More

Tobacco: cigarettes - packs/day: 1/2 / 1 / 2 / >2
Cigars/day_____ Chew_____

Exercise: describe what type_____
How many hours/day? <1 - 1 - 2 - 3 - 4 - >4
Days/week? 1 - 2 - 3 - 4 - 5 - 6 - 7

Hobbies_____

Sleep: average no. hours/night - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Difficulty going to sleep? ---------- Yes / No
Early awakening? ---------- Yes / No
Vivid dreams or nightmares? ---------- Yes / No
Do you nap during the day? ---------- Yes / No

Marital Status: (circle): S M D W Other_____
Number & ages of children_____
Who lives in your household? _____

Occupation_____ Retired?_____

Highest degree of education: (circle if degree awarded)
Grammar / High School / College / Post-graduate
Are you right or left handed? Right / Left

X. Stress profile

Rate the following stressors on a scale from 0 (none) or 1 (low) to 10 (high).

_____ Marital (etc) conflicts? _____
_____ Family stresses? _____
_____ Financial problems? _____
_____ Work/school related? _____
_____ Other: _____

How well are you handling these problems? (circle and describe)
Poorly / Fairly well / Well / Very well

_____

XI. Psychiatric history (Please provide descriptions if appropriate)

Have you ever had strange or "out of body" experiences?_____
Have you ever seen or heard things that no-one else can?_____
Do you believe you or others you know have special powers?_____
Do you sometimes think that people are out to get you?_____

Have you ever been very depressed?_____
Are you very depressed now?_____

Have you ever been really "speeded up", having a great deal of energy, including not needing much sleep?_____

Do you consider yourself a generally happy person?_____
Are you calm and content?_____
Are you often bored or restless?_____
Do you sometimes worry without specific reason?_____
Do you ever feel anxious without reason?_____

Have you ever had a problem with alcohol or other drugs?_____
Have you ever had anorexia nervosa or bulemia?_____

Have you ever received psychological or psychiatric treatment for mental or emotional problems?_____

XII. Is there anything else which you feel is less than satisfactory in your life?_____
_____

_____

XIII. What is your main goal
_____Find a reason for the headache.
_____Obtain control of the pain.
_____Cure the headache.
_____Obtain control of my life.
_____Stress management.
_____Make sure I don't have a brain tumor.
_____Other_____