HEADACHE QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

BIRTHDATE: _____ AGE: _____

Please answer the following questions regarding your headaches.

A. HEADACHE ONSET

1) My headaches started_____ years ago at _____ years of age.
2) Any associated head injury? …YES / NO Loss of Consciousness? ____ YES / NO
3) Any history of infection around your brain or spinal cord? _____ YES / NO

Comments: _____

B. CURRENT HEADACHE FREQUENCY

1) My headaches occur____ all the time ____ daily but not all the time ____ times per week ____ times per month.
2) Has the frequency recently changed? YES / NO

Comments: _____

C. HEADACHE LOCATION (Circle the most common locations)

Right Sided	Left Sided	Both Sides	Entire Head
Back of Head	Forehead	Neck	Behind/Around Eyes
Temple	Other: _____		

D. HEADACHE QUALITY

Throbbing / Pulsating
Pressure / Squeezing / Bandlike
Stabbing / Sharp
Dull / Nagging / Aching
Comments: _____

E. HEADACHE TIMING (Circle any that apply)

My headaches tend to occur:	when I wake up	in the morning	in the afternoon
	after work	in the evening	during sleep

F. HEADACHE DURATION:

1) My headaches typically last _____ hours if treated.
2) My headaches typically last _____ hours if not treated.

G. HEADACHES SEVERITY (Circle the average pain and limitation of your headaches.)

1) Average headache pain is 1 2 3 4 5 6 7 8 9 10 out of 10
Mild Average Severe

2) My headaches usually limit my activity as follows:

1= They allow normal activity
2= They are disturbing and limit some normal activity. Bed rest is not necessary.
3= Normal activity has to be discontinued. Bed rest may be necessary.
4= Bed rest is necessary

Comments: _____

H. ASSOCIATED SYMPTOMS (Circle any symptoms that occur before or during your headaches.)

Sensitivity to light or sound

Nausea	Vomiting	Fatigue	Balance Problems
Tingling	Dizziness	Numbness	Flashing Lights
Sweating	Watering Eyes	Difficulty Swallowing	Visual Changes

Other: _____
_____

I. Do you have an **aura** before your headaches? (ie. Visual changes, numbness)
Never / Sometimes / Commonly / Always

J. PRECIPITATING FACTORS (Circle the appropriate answer)

1) Do you have problems falling asleep, staying asleep, or waking up often at night? YES / NO
2) Do you have a job or other stress? YES / NO
3) Do you find it difficult to relax? YES / NO
4) Do you feel anxious or depressed? YES / NO
5) Do any of the following trigger or worsen your headaches?

Missed meal	Alcohol	MSG	Processed Meats
Chocolate	Citrus	Cheese	NutraSweet
Coffee/Tea	Bending over	Straining	Coughing
Sexual activity	Stress	Walking up stairs	Too much / little sleep

Comments: _____

8) Female Patients:
My headaches are worse around my periods? YES / NO
My headaches are worse during pregnancy? YES / NO

Comments: _____

Ortho ***Neuro*** NAME _____ DATE _____

J. PAST MEDICATIONS

(Circle medications used for headaches in the past and comment on the reason for stopping)

ACUTE PAIN TREATMENT	**Helps**	**Allergy/Adverse Reaction**	**Doesn't Help**
Acetaminophen (Tylenol)			
Ibuprofen (Motrin, Advil)			

Indomethacin (Indocin)			
Naproxen (Naprosen, Aleve)			
Duradrine Midrin)			
(Cafergot)			
Compazine, Phenergan, or Ragalan			
Floricet / Fiorinal / Butalbital			
Hydrocodone (Lortab, Vicodin)			
Codeine			
Oxycodone (Percocet/ Oxycontin)			
Morphine			
Dihydroergotamine (DHE)			
Sumatriptan Injection (Sumavel)			
Sumatriptan (Imitrex)			
Teximet (Imitrex/Naproxen)			
Almotriptan (Axert)			
Rizatriptan (Maxalt)			
Naratriptan (Amerge)			
Frovatriptan (Frova)			
Zolmitriptan (Zomig)			
Prednisone (Deltasone)			
Dexamathasone (Decagron)			
Other _____			
PREVENTIVE TREATMENT	**Helps**	**Allergy/Adverse Reaction**	**Doesn't Help**
Atenolol (Tenormin)			
Metoprolol (Lopressor)			
Nadolol (Corgard)			
Propranolol (Inderal)			
Verapamil (Calan, Isoptin)			
Diltiazem (Cardizem)			
Amlodipine (Norvasc)			
Amitripyline (Elavil)			
Nortripyline (Pamelor)			
Fluoxetine (Prozac)			
Sertaline (Zoloft)			
Escitalopran (Lexapro)			
Paroxetine (Paxil)			
Venlafaxine (Effexor)			
Nefazodone (Serzone)			
Duloxetine (Cymbalta)			
Milnacipran (Savella)			
Desvenlafaxine (Pristiq)			
Valproic Acid (Depakote)			
Topirimate Topamax)			
Gabapentin (Neurontin)			
Pregabalin (Lyrica)			
Levetiracetam (Keppra)			
Lacosamide (Vimpat)			
Zonisamide (Zonegram)			
Cyproheptadine (Periactin)			
Botulinum Toxin (Botox)			
Physical Therapy			
Chiropractic			
Other _____			

Patient Signature _____ Date _____

Physician Signature _____ Date _____