

Headache Questionnaire

When did the headaches first begin? _____

How often do they occur? _____

Do the headaches occur at a certain time of day? _____

Are the headaches constant, or do they come and go? _____

Have the headaches changed in (circle any): Severity / Duration / Frequency?

If changed, how? _____

Is the headache worse with position (circle one): Laying / Standing / Not effected

What part of your head hurts? _____

What does the pain feel like? _____

Do the headaches stop you from any daily or social activities? no yes, If yes, please list: _____

Are there any warning signs before the headache begins? no yes, If yes, please list: _____

Do the headaches ever wake you up while sleeping? no yes

Does rest or sleep relieve the headaches? no yes

Are nasal congestion, sinusitis or allergies associated with the headache? no yes

Any Nausea or vomiting with the headaches? no yes

Any Sensitivity to light with the headaches? no yes

Any pain with neck movements ? no yes

What Headache Medications have you tried in the past and why were they stopped ?

Do you have any triggers that bring on a headache: no yes, if yes check them:

- | | | |
|--|---------------------|---------------------------|
| _____ 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 |
| _____ Medications, Which ones? _____ | | |
| _____ Certain foods, Which ones? _____ | | |
| _____ Other triggers: _____ | | |

Have you had other therapies? If so, please list:

Name: _____ DOB: _____ Date _____