

# Headache Questionnaire

*How do you rate the severity of your headaches on a scale of 1 to 5?*

1 = the least pain ever felt

3

5 = the worst pain ever felt

2 \_\_\_\_\_  
\_\_\_\_\_

4 \_\_\_\_\_  
\_\_\_\_\_

*Mark those that Appropriately Describe Your Headaches*

*How would you describe your pain?*

Tight band around your head? \_\_\_\_\_

Pounding pain in your head? \_\_\_\_\_

On one side of your head? \_\_\_\_\_

Over your eyes? \_\_\_\_\_

*Do you experience associate pain in your:*

Neck or shoulders? \_\_\_\_\_

Teeth pain? \_\_\_\_\_

Facial pain? \_\_\_\_\_

Ear pain? \_\_\_\_\_

Chest when you bend your head forward? \_\_\_\_\_

*Do you have associated events with your headaches like:*

See bright spots or flashes before the pain starts? \_\_\_\_\_

Nausea and vomiting? \_\_\_\_\_

Slurred speech ? \_\_\_\_\_

Change in vision? \_\_\_\_\_

Numbness or weakness in your arms or legs? \_\_\_\_\_

Fever with stiff neck? \_\_\_\_\_

*What time of the day do you get headaches?*

After an activity like driving or working on a computer? \_\_\_\_\_

At the same time each week or month, after specific events, or after eating certain foods? \_\_\_\_\_

Last longer than 3 days? \_\_\_\_\_

In the morning? \_\_\_\_\_

*How do your headaches affect your activities?*

I can continue my daily activities \_\_\_\_\_

I cannot continue my daily activities \_\_\_\_\_

*What treatment have you tried?*

Tylenol, Advil, or over the counter analgesics & ibuprofen \_\_\_\_\_

Narcotic pain reliever \_\_\_\_\_

Prescription strength migraine medications \_\_\_\_\_

Sleep, massage or heat packs \_\_\_\_\_

*Has your headache been diagnosed in conjunction with another illness like:*

Sinusitis \_\_\_\_\_

Allergies \_\_\_\_\_

Meningitis \_\_\_\_\_

**Do you have any other information about your headaches that would be essential to your care?**

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