HEADACHE QUESTIONNAIRE

DEMOGRAPHIC INFORMATION:

Name: _____ Date:_____

Age: _____ Gender: _____ Handedness: L_____ R _____

Who referred you to APM? _____

HEADACHE HISTORY:

When did your headaches start? _____

_____

What was the initial cause? _____

_____

Since your headaches began, have they changed? _____ Yes _____ No

My headaches are (check all that apply):

____ More frequent	____ Less frequent	____ More severe	____Less severe
____ More continuous	____ Less continuous	____ More predictable	___ Less predictable
____ Last longer	____Do not last as long	____ Different in quality	

Are there others in your family who have headaches? _____ Yes _____ No

____ Immediate family ____ Mother's side of family ____ Father's side of family

HEADACHE CHARACTERISTICS:

How many different types of headaches do you have per: day _____week_____ month_____

How many severe/debilitating headaches do you have per: day _____week_____ month_____

How many mild/moderate headaches do you have per: day _____week_____ month_____

How long does each headache last? minutes_____ hours_____ days_____

Additional comment:_____

_____

PAIN DESCRIPTION:

Please rate you pain on the following scale, where 0 is no pain and 10 is the worst pain possible.

0 1 2 3 4 5 6 7 8 9 10

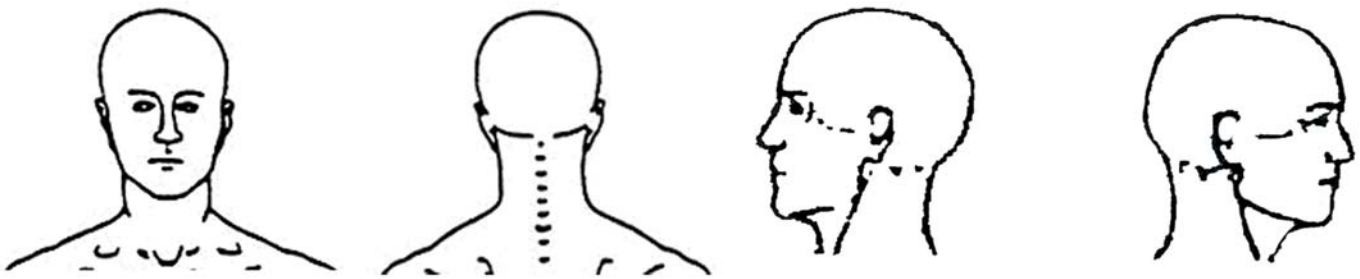
Your pain right now: _____ Your pain at its best: _____

Your typical headache: _____ Your headache at its worst: _____

On the body chart below:

1. Please mark the areas of your pain. You may use the key to indicate different kinds of pain sensation.
2. Please number each painful area in order of the most troublesome, i.e., 1 – 10 on the diagram.

→	Shooting	***	Burning
////	Stabbing	∞	Throbbing
XXX	Dull/Aching	===	Numbness



Indicate when you have the symptoms listed above:

	Never	Occasionally	Frequently	Always	When severe
Shooting					
Stabbing					
Dull/Aching					
Burning					
Throbbing					
Numbness					

What makes your pain better? (Please check all that apply)

☐ Lying down	☐ Walking	☐ Sitting	☐ Standing	☐ Medication
☐ Sleep	☐ Heat	☐ Massage	☐ Exercise	☐ Stretching
☐ Traction	☐ TENS	☐ Ice	☐ Biofeedback	☐ Compression

What makes your pain worse? (Please check all that apply)

☐ Standing	☐ Walking	☐ Bending	☐ Stress	☐ Reaching overhead
☐ Sitting	☐ Sneezing	☐ Weather	☐ Driving	☐ Lack of sleep
☐ Lying down	☐ Coughing	☐ Lifting	☐ Reaching	☐ Sexual activity

ASSOCIATED SYMPTOMS:

Please mark which of the following symptoms you have and their relationship to your headaches.

	Have Symptom	Before Headache	During Headache	When Severe		Have Symptom	Before Headache	During Headache	When Severe
Nausea					Cold hands or feet				
Vomiting					Balance Problems				
Dizziness					Memory Problems				
Sensitivity to light					Attention/ Concentration				
Sensitivity to noise					Bladder Problems				
Sensitivity to smells					Bowel Problems				
Weakness					Jaw Pain				
Tiredness					Neck/Back Pain				
Swelling					Neck/Back Stiffness				
Nasal Congestion					Visual Abnormalities				
Sinus Drainage					Unusual Smell/Taste				
Numbness					Hearing Abnormalities				
Irritability					Unusual Sensations				
Sweating					Loss of sensation to limbs/face				
Anxiety					Loss of strength to limbs				

WHICH OF THE FOLLOWING SEEM TO BRING HEADACHES ON?

☐ Fatigue	☐ Chewing/Clenching teeth
☐ Lack of sleep	☐ Sinus problems
☐ Oversleeping	☐ Weather
☐ Menstrual cycle	☐ Exercise
☐ Stress/Tension	☐ Medications
☐ Skipping meals	☐ Smells/Perfumes
☐ Hunger	☐ Coughing
☐ Food allergies/Sensitivity	☐ Other_____

SLEEP

Do you have severe nightmares?	☐ Yes	☐ No
Do you have trouble falling asleep?	☐ Yes	☐ No
Average number of hours of sleep per night? _____		
How many times per night do you wake up? _____		
Do you wake up unusually early in the morning?	☐ Yes	☐ No
Do you wake up with a headache?	☐ Yes	☐ No
Do you grind your teeth at night?	☐ Yes	☐ No
Do you snore excessively loudly at night?	☐ Yes	☐ No
Do you stop breathing in your sleep?	☐ Yes	☐ No
Is your sleep restful?	☐ Yes	☐ No

PLEASE INDICATE HOW MUCH YOU AGREE WITH THE FOLLING STATEMENTS:					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I worry about my headaches					
My headaches are predictable					
I am concerned that something is seriously wrong with me					
I am a perfectionist					
There is never enough time to do the things I need to do					
I believe my headaches would be better if I could relax more					
I take medications as soon as possible to control my headaches					
I try to wait as long as possible before taking medications					
I sometimes take more medications that I am supposed to use					
I avoid medications because I am afraid of addiction					
I am concerned that I am addicted to my medications					
I try to get as much done before my headaches get severe					
There are many things I am unable to do because of my headaches					
I have trouble saying no to people					
I have trouble taking care of myself					

MEDICAL TREATMENT:

Current Treating Physician for Headaches: _____

Family/Primary Care Physician: _____

Other Physicians/Health Care Providers currently treating you: _____

_____

_____

List any Physician/Health Care Providers who have treated you in the past for you headaches.
(If you do not know their names, please provide their specialty instead): _____

_____

_____

CURRENT MEDICATIONS:

NAME:	DOSE	HOW OFTEN ARE YOU TAKING IT	REASON FOR TAKING IT	HELPFUL?	
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No

PAST MEDICATIONS:

NAME:	REASON FOR STOPPING IT?	NAME:	REASON FOR STOPPING IT?

ALLERGIES:

Please list any medication allergies you have. _____

_____

_____

Are you allergic to latex? _____ Yes _____ No

IN THE LAST THREE MONTHS, HOW MANY DAYS DID YOU:	DAYS
Have a headache (if a headache lasted more than a day, count each day	
See a health care provider for headaches	
Go to a minor emergency center for headaches	
Call a physician's office to receive emergency pain medication for headaches	
Miss work or school because of your headaches	
Have your productivity at work or school reduced by half or more because of headaches	
Not do household work because of headaches	
Have your productivity in household reduced by half or more because of headaches	
Miss family, social, or leisure activities because of your headaches	
On a scale of 0 to 10, on average how painful were these headaches?	

DIAGNOSTIC TESTING:

☐ Plain X-Ray	☐ MRI	☐ Myelogram
If yes, where_____	If yes, where_____	If yes, where_____
☐ CAT Scan	☐ EMG/Nerve Conduction	☐ Diagnostic Blocks
If yes, where_____	If yes, where_____	If yes, where_____

HABITS:	How often?	Have you ever had a problem with this?	
Smoking	_____per day	☐ yes ☐ no	
Alcohol Consumption	Beer _____per week Wine _____per week Liquor _____per week	☐ yes ☐ no	
Recreational Drugs	_____per day	☐ yes ☐ no	
Coffee	_____per day	☐ yes ☐ no	☐ Caffeinated ☐ Decaf
Soda	_____per day	☐ yes ☐ no	☐ Caffeinated ☐ Decaf
Tea	_____per day	☐ yes ☐ no	☐ Caffeinated ☐ Decaf
Exercise	_____per week	☐ yes ☐ no	
Relaxation/Stress Management	_____per week	☐ yes ☐ no	

SOCIAL HISTORY:

Current Marital Status: □ Single, never married □ Married/live-in _____ years

□ Divorced _____years □ Widowed _____ years

Number of children by present marriage/relationship: _____

Number of step-children living with you: _____

Number of previous marriages: _____

Number of children by previous marriages/relationships: _____

	EXCELLENT	GOOD	FAIR	POOR
Describe the quality of your childhood:				
Describe the quality of your life:				
Describe the quality of your social support system				

Military History: □ Not applicable □ Active Duty □ Honorable Discharge

□ Medical Discharge □ Dishonorable Discharge

Legal History: □ No legal problems □ Prior history of legal problems □ Current legal problems

Work History: □ Currently Working □ Not Working

Current job title: _____

Job satisfaction: □ Excellent □ Good □ Fair □ Poor

Please indicate any additional information that you feel might be helpful to us in treating you:

_____

_____

_____

_____

_____

_____