Child Neurology SOLUTIONS

HEADACHE QUESTIONNAIRE

Date:_____

We would appreciate your cooperation in filling out this form. In our evaluation of headache, your history is typically our most valuable tool for diagnosis and subsequent treatment. If you have any questions regarding this form, please ask.

PATIENT PORTION

Name: _____

Age: _____ Sex.: M F (circle one) Date of birth: _____

Headache History

How old were you when you had your first significant headache? ___

Over the past 2 months, how many individual headache attacks have you averaged per month?_____

_ How long does a typical headache attack last? (Circle one)

a) 0-1 hr b) > 1-6 hr c) > 6-12 hr d) > 12-24 hr e) > 24-48 hr f) > 48 - 72 hr
g) > 72 hr h) constant i) too variable j) unknown

Has there been any recent change in the character or frequency of your headaches? No Yes

If yes, please specify what type of change: _____ _____

Check any of the following factors which seem to trigger a headache attack in you:

- ☐ missing sleep
- ☐ menstruation
- ☐ emotional stress
- ☐ odors (please list:
- ☐ fatigue
- ☐ missing meals
- ☐ caffeine
- ☐ changes in weather
- ☐ other (please specify:)

Are your headaches ever incapacitating (e.g., have to leave work/school or lie down undisturbed)? No Yes

How many days per month are you incapacitated by headache?__ _____

Where on this line does your typical (average) headache fall?

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Level 1 (minimal pain) Level 10(unbearable pain)

Overall, how disabled do you feel you have been by headaches over the past 2 months?

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No problem with headaches Totally disabled by frequent/severe headache

Is your headache pain ever throbbing? No Yes Unknown
(If yes, what percent of your headache attacks involve "throbbing" pain? ____%

Is your headache ever localized to one side? _____% unknown

Does your headache typically occur at a certain time of day or on certain days of the week or month?
No Yes (If yes, please describe)_____

Do you have any warning symptoms which alert you that you are going to have a headache attack?
No Yes (If yes, what type of warning do you have?)_____

Do you ever experience any of the following symptoms in association with your headache attacks (before, during, or after)? Please check the appropriate boxes:

- ☐ nasal congestion **unknown**
- ☐ nausea (with what % of attacks do you experience nausea? ____% unknown
- ☐ vomiting (with what % of attacks do you experience vomiting?____% unknown
- ☐ diarrhea
- ☐ visual changes (e.g.s, visual distortion, "flash cubes", "zig-zags", "blind spots","sparkles"). (Please describe:).
- ☐ inability to tolerate bright light (photophobia)
- ☐ inability to tolerate loud noise (phonophobia)
- ☐ numbness and/or tingling in face, arm, or leg (Please describe:)._____
- ☐ speech disturbance (Please describe:)._____
- ☐ loss of balance
- ☐ vertigo (i.e., a spinning/"merry-go-around" sensation)
- ☐ extreme thirst, food cravings (Please describe:).

What makes your headache worse? _____

What seems to help your headache?_____

Medical and Social History

Are you currently having difficulties with your sleeping (insomnia, early morning awakening, "always sleepy", etc.)? No Yes
Do you consider yourself to be currently under a significant amount of stress? No Yes
Do you adhere to a regular exercise program? No Yes

Do you eat at regular intervals? No Yes
Do you sleep at regular intervals? No Yes

Are you currently receiving formal treatment (counseling and/or medications) for anxiety or depression? No Yes
Please check the appropriate boxes:

- ☐ history of snoring
- ☐ history of lung disease
- ☐ anemia
- ☐ hypertension (high blood pressure)
- ☐ arthritis
- ☐ history of thyroid disease
- ☐ treated for depression in past
- ☐ recent weight loss
- ☐ past or present problems with significant motion sickness
- ☐ do you smoke cigarettes now? (Number of cigarettes per day)
- ☐ any significant head injury? (if yes, within the past six months? No Yes)
- ☐ history of seizures
- ☐ any other significant medical or psychiatric problem or conditions for which you are under medical care? If yes, please explain: _____

What medications are you presently taking? (Please include over-the-counter medications, herbs, and birth control pills):
_____

Have you taken oral contraceptives in the past? No Yes

(If yes, effect on your headaches? Better Worse No change Can't recall

Have you seen a doctor in the past for your headaches? No Yes His/Her diagnosis (if known):_____

Have you had a CAT scan in the past? No Yes unknown

Have you had a brain MRI scan in the past? No Yes unknown

What medications have you tried in the past for your headaches (e.g.s., Inderal, Cafergot, Elavil)?

Family History

Has anyone in your family had a significant problem with headaches or been diagnosed as having migraine or "sick" headaches? No Yes (If yes, who?) unknown