

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 your 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

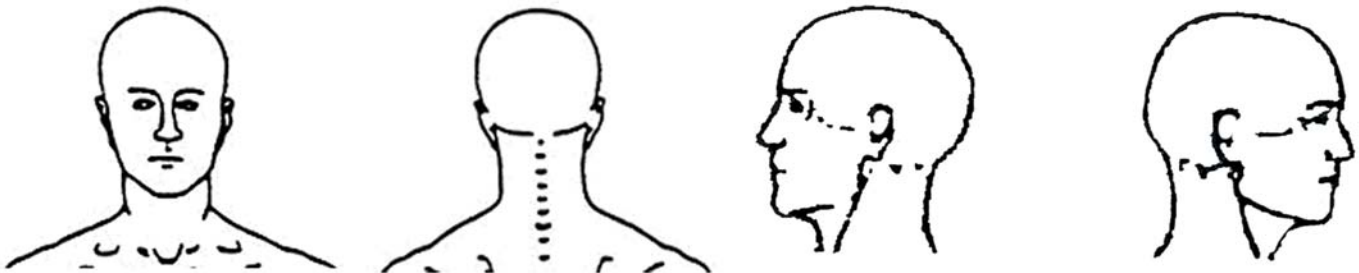
Your pain right now: _____ Your pain at its best: _____

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)

- | | | | | |
|-------------------------------------|----------------------------------|----------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Walking | <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Heat | <input type="checkbox"/> Massage | <input type="checkbox"/> Exercise | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Traction | <input type="checkbox"/> TENS | <input type="checkbox"/> Ice | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Compression |

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

- | | | | | |
|-------------------------------------|-----------------------------------|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Bending | <input type="checkbox"/> Stress | <input type="checkbox"/> Reaching overhead |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Weather | <input type="checkbox"/> Driving | <input type="checkbox"/> Lack of sleep |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Coughing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Reaching | <input type="checkbox"/> 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?

- | | |
|---|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chewing/Clenching teeth |
| <input type="checkbox"/> Lack of sleep | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Oversleeping | <input type="checkbox"/> Weather |
| <input type="checkbox"/> Menstrual cycle | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Stress/Tension | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Skipping meals | <input type="checkbox"/> Smells/Perfumes |
| <input type="checkbox"/> Hunger | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Food allergies/Sensitivity | <input type="checkbox"/> Other _____ |

SLEEP

Do you have severe nightmares?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble falling asleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wake up with a headache?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you grind your teeth at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you snore excessively loudly at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you stop breathing in your sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your sleep restful?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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

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:		
<input type="checkbox"/> Plain X-Ray If yes, where _____	<input type="checkbox"/> MRI If yes, where _____	<input type="checkbox"/> Myelogram If yes, where _____
<input type="checkbox"/> CAT Scan If yes, where _____	<input type="checkbox"/> EMG/Nerve Conduction If yes, where _____	<input type="checkbox"/> Diagnostic Blocks If yes, where _____

HABITS:	How often?	Have you ever had a problem with this?	
Smoking	_____per day	<input type="checkbox"/> yes	<input type="checkbox"/> no
Alcohol Consumption	Beer _____per week Wine _____per week Liquor _____per week	<input type="checkbox"/> yes	<input type="checkbox"/> no
Recreational Drugs	_____per day	<input type="checkbox"/> yes	<input type="checkbox"/> no
Coffee	_____per day	<input type="checkbox"/> yes	<input type="checkbox"/> no
Soda	_____per day	<input type="checkbox"/> yes	<input type="checkbox"/> no
Tea	_____per day	<input type="checkbox"/> yes	<input type="checkbox"/> no
Exercise	_____per week	<input type="checkbox"/> yes	<input type="checkbox"/> no
Relaxation/Stress Management	_____per week	<input type="checkbox"/> yes	<input type="checkbox"/> 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:
