

# CCHMC New Visit Headache Questionnaire

Please answer the following questions to the best of your ability

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of visit: \_\_\_\_\_

**ONSET:** At what age did you begin having headaches of ANY type? \_\_\_\_\_ Years old

**FREQUENCY:** How often do the headaches occur?

<1/month 1 to 3 /month 1 /week 2 to 3 /week >3 /week Daily Always

**DURATION:** On average how long do headaches usually last? <1 hr. 1-2 hrs. 2-4 hrs. 4-6 hrs. >6 hrs.

**SEVERITY:** On a scale of 0 to 10, what is the severity of your headache? (0 = no pain; 5 = moderate pain; 10 = worst pain)

Circle best answer: 

1	2	3	4	5	6	7	8	9	10
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Has the frequency, duration or severity of the headaches changed? Yes No If so how? \_\_\_\_\_

**TIMING:** Does the headache occur at a particular time of the day? Yes No

Waking up Morning Afternoon Evening Night Wake from sleep Other \_\_\_\_\_

**LOCATION:** Where does your headache hurt?

Both sides Left side Right side Front Top Back Around eyes Behind eyes All over

**DESCRIPTION:** Describe your headache pain?

Throbbing Squeezing Stabbing Pinching Pressure Burning Sharp Constant Dull Other \_\_\_\_\_

**AURAS:** Are there any warnings (auras) that the headache is going to start? Yes No

Vision Changes (loss of vision, blurry vision, spots/floaters, tunnel vision, etc.) Taste Trouble talking

Sensory (numbness, tingling, pins and needles) Weakness on one side of body Other \_\_\_\_\_

**ASSOCIATED SYMPTOMS:** What symptoms occur with your headache?

Nausea Vomiting Sensitivity to light Sensitivity to sound Sensitivity to smells Spinning sensation Changes in vision Tearing eyes

Runny nose Ringing in the ears Confusion Stomach pain Other \_\_\_\_\_

**TRIGGERS:** Are there triggers that can start a headache? Yes No

Sleep - too little / too much Inadequate hydration Hunger / Skipping meals Stress Weather Menstruation

Food / Chocolate / Caffeine Light Noises Smells School Concentration Other \_\_\_\_\_

**Headache Treatment:**

What medications are you CURRENTLY taking for your headaches? \_\_\_\_\_

How many days a week do you use these medications to TREAT your headaches? \_\_\_\_\_ days/week

Medications you are taking to PREVENT headaches: \_\_\_\_\_

Vitamins or health foods for headaches: \_\_\_\_\_

**Headache Disability:** These questions assess how much headaches are affecting your day-to-day activity. Please answer based on ALL headaches you have had in the last TWO months

How many days of school were missed due to headaches? \_\_\_\_\_

How many days were you unable to participate in activities (play, going out, sports) because of you headaches? \_\_\_\_\_

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**OFFICE use only:**

Is the headache due to medication overuse: YES  NO

Abortive Therapy: NSAID  Triptan  None

Is this a chronic headache: YES  NO

Preventative Therapy: Nutraceutical  CBT