Initial Headache Questionnaire

BRAIN-BASED PRACTITIONER'S GUIDE

Name: _____ Date:_____

1. How long have you had these headaches? _____
2. Did the headaches start after an accident, illness, or infection? ☐ Yes ☐ No
3. The headaches: ☐ Are constant ☐ Come and go
4. How frequently do the headaches occur? ☐ Daily ☐ Weekly ☐ Monthly
5. How long do the headaches typicall last? _____
6. Do the headaches occur at a certain time of day? ☐ Morning ☐ Afternoon ☐ Night
7. Are the headaches becoming: ☐ Stronger ☐ Longer ☐ More frequent
8. Do the headaches ever wake you when you are asleep? ☐ Yes ☐ No
9. Does rest or sleep relieve the headaches? ☐ Yes ☐ No
10. Do the headaches stop you from doing regular daily activities? ☐ Yes ☐ No
11. Have you ever missed work or school because of a headache? ☐ Yes ☐ No
12. Is the headache pain: ☐ Intense from the start ☐ Mild at first and then worse over time
13. Please check any items below that you suspect may be triggers for the headaches:

☐ Odors	☐ Fatigue	☐ School
☐ Hunger or missing meals	☐ Loud noises	☐ Anxiety or stress
☐ Exercise or playing	☐ Ice cream	☐ Family problems
☐ Too much sleep or sleeping in	☐ Bright lights	☐ Menstrual cycle
☐ Too little sleep or staying up late	☐ Sunshine	☐ Birth control pills
☐ Riding in a car	☐ Hot weather	☐ Alcohol

☐ Medications – Which ones?

☐ Certain foods – Which ones?

14. Are the headaches associated with nasal congestion, sinusitis, or allergies?

☐ Yes

☐ No

15. Are there any warning signs BEFORE the headache begins?

☐ Pallor.	☐ Mood swings (either high or low)	☐ Irritability
☐ Dizziness	☐ Tired, sleepy or yawning	☐ Increased appetite
☐ Rings around the eyes	☐ Hyperactivity	☐ Craving sweets

☐ Eye problems such as blurred vision, black spots, flashing lights, or double vision

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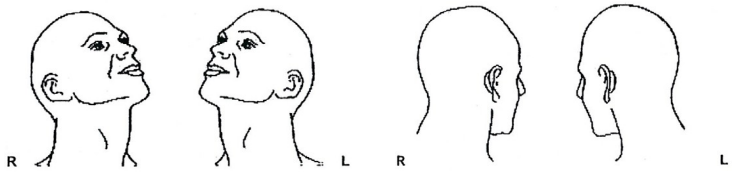
16. Where is the headache located?

☐ Left side ☐ Forehead ☐ All around the head
☐ Right side ☐ Temples ☐ Top of the head
☐ Neck ☐ Back of the head

If the pain is located in another part of the head, please describe or mark the location:



17. What does the pain feel like?

☐ Exploding ☐ Sharp ☐ Throbbing/pounding
☐ Dull ☐ Aching ☐ Pressure
☐ Tightness (like a rubber band wrapped around the head)

Please describe the pain in your own words:

18. Do you have any other symptoms when you have a headache?

☐ Nausea ☐ Stomach pains ☐ Weakness in the arms or legs
☐ Vomiting ☐ Confusion ☐ Numbness to the arms or legs
☐ Light sensitivity ☐ Odor sensitivity ☐ Sound sensitivity

Please describe other symptoms:

19. Describe any major stresses in the last year, including relationship changes, relocation, changes at work or school, or loss of a loved one:

20. Have you been treated for headaches in the past? ☐ Yes ☐ No

21. If you have been treated for these or other headaches, were any of the following tests performed?

☐ CT scan ☐ Eye exam ☐ Sinus X-rays
☐ MRI ☐ Dental exam ☐ Allergy tests
☐ Spinal tap ☐ Blood tests

Other tests:

22. Which medications or treatments have you tried, and how long did you try them for?