Headache Questionnaire

When did the headaches first begin?__________________________________________

How often do they occur?____________________________________________________

Do the headaches occur at a certain time of day? ________________________________

Are the headaches constant, or do they come and go? ____________________________

Have the headaches changed in (circle any): Severity / Duration / Frequency? 
If changed, how?____________________________________________________________

Is the headache worse with position (circle one): Laying / Standing / Not effected

What part of your head hurts? __________________________________________________

What does the pain feel like? __________________________________________________

Do the headaches stop you from any daily or social activities?  ☒ no ☐ yes, If yes, please list: ________________________________________________________________

Are there any warning signs before the headache begins?  ☒ no ☐ yes, If yes, please list: ________________________________________________________________

Do the headaches ever wake you up while sleeping?  ☒ no ☐ yes

Does rest or sleep relieve the headaches?  ☒ no ☐ yes

Are nasal congestion, sinusitis or allergies associated with the headache?  ☒ no ☐ yes

Any Nausea or vomiting with the headaches?  ☒ no ☐ yes

Any Sensitivity to light with the headaches?  ☒ no ☐ yes

Any pain with neck movements?  ☒ no ☐ yes

What Headache Medications have you tried in the past and why were they stopped?
______________________________________________________________
______________________________________________________________
______________________________________________________________

Do you have any triggers that bring on a headache:  ☒ no ☐ yes, if yes check them:

☐ Odors (Perfume, cigarettes) ☐ Fatigue ☐ School
☐ Hunger (missing meals) ☐ Loud noises ☐ Anxiety or stress
☐ Exercise or playing ☐ Ice Cream ☐ Family problems
☐ Too much sleep (sleeping in) ☐ Bright Lights ☐ Menstrual cycles
☐ Too little sleep (staying up late) ☐ Sunshine ☐ Birth Control Pills
☐ Riding in a car ☐ Hot weather ☐ Alcohol
☐ Medications, Which ones?
☐ Certain foods, Which ones?
☐ Other triggers: ________________________________________________________________

Have you had other therapies? If so, please list:
________________________________________________________________________
________________________________________________________________________

Name:_________________________________________________________ DOB:____________ Date________________