Print Form

Florida Center for Headache & Neurology

Headache Questionnaire

Patient Name:

Date:

Symptoms

l. Describe a typical headache episode:

2. How would you rate the pain? (circle the number that applies)

NO PAIN	VERY MILD	UNCOMFORTABLE	PAINFUL	EXREMELY PAINFUL
0	2-4	5-6	7-8	9-10

3. How often do your Headaches Occur?

- ☐ Daily
- ☐ Weekly (if so how many times per week) _____
- ☐ Less than once a month.

4. Do your headaches result in lost time at work, prevent you or could prevent you from performing your daily activities?

- ☐ YES
- ☐ NO
- ☐ SOMETIMES

5. How long do your headaches last?

- ☐ Minutes
- ☐ Hours
- ☐ Days

6. Which of the following best describes your pain? (check all that apply)

- ☐ DULL
- ☐ BURNING
- ☐ ACHING
- ☐ THROBBING
- ☐ PULSATING
- ☐ STABBING
- ☐ ICE CREAM LIKE
- ☐ BANDLIKE

7. Where does the pain occur? (check all that apply)

- ☐ ON BOTH SIDES OF HEAD
- ☐ BEHIND OR AROUND ONE EYE
- ☐ ON ONE SIDE OF THE HEAD
- ☐ IN THE NECK or BACK OF THE HEAD

8. Are any of the following symptoms associated with your headaches? (check all that apply)

☐ CHEST PAIN	☐ SHORTNESS OF BREATH	☐ PALPITATIONS
☐ SENSITIVE TO LIGHT	☐ SENSITIVITY TO LOUD NOISE	☐ NASAL CONGESTION
☐ TEARING	☐ EYELID DROOPING	☐ VERTIGO
☐ PARALYSIS	☐ NUMBNESS or TINGLING	☐ BLURRED VISION
☐ SHIMMERING LIGHTS	☐ FLOATERS	☐ ZIG ZAGS
☐ LOSS OF VISION	☐ CONFUSION	☐ NECK STIFFNESS

9. What sorts of things can trigger your headaches? (check all that apply)

☐ MENSTRUAL CYCLE
☐ ALCOHOL
☐ SMOKE
☐ STRESS
☐ SMELLS
☐ EXERCISE
☐ CHANGES IN THE WEATHER (Low pressure systems or thunderstorms)
☐ CERTAIN FOODS _____
☐ MEDICATIONS_____
☐ OTHER_____

10. Do you experience a warning the day before one of your headaches such as increased energy, irritability, decreased energy?

☐ Yes
☐ No

11. Do you have or have you had any of the following? (Check all that apply)

☐ Uncontrolled Blood pressure	☐ Stroke or Mini Stroke (TIA)
☐ Heart Attack or Blocked Arteries (CAD)	☐ Abnormal Heart Beat (Arrythmia)
☐ Raynaud's Disease	☐ Currently Pregnant

12. Which of the following over the counter medications have you taken for your headache?

☐ Tylenol
☐ Advil (Ibuprofen)
☐ Aleve (Naprosyn)
☐ Excedrin (BC, Goodies etc)
☐ Aspirin

13. Have you ever taken any prescription medications to abort your headache? If so which ones? What were the results?

14. Have you ever taken any prescription medications to prevent your headache? If so which ones? What were the results?

15. Have you tried any alternative treatments for headache such as?

☐ Massage Therapy, If yes did it work ☐ Yes ☐ No
☐ Chiropractic Manipulation, If yes did it work ☐ Yes ☐ No
☐ Acupuncture, If yes did it work ☐ Yes ☐ No
☐ Behavioral Modification i.e. Biofeedback etc, If yes did it work ☐ Yes ☐ No
☐ Herbal Treatments If yes which ones _____