

HEADACHE QUESTIONNAIRE

NAME: _____ DATE: _____

HOW LONG HAVE YOU HAD HEADACHES? _____

WHEN DID THIS EPISODE BEGIN? _____

HOW OFTEN DO YOU GET A HEADACHE? _____

DO YOUR HEADACHES COME IN GROUPS? Y N

DESCRIBE YOUR HEADACHE PAIN:

ON A SCALE OF 1-10 WITH 10 BEING THE WORST PLEASE CIRCLE YOUR LEVEL OF PAIN:

1 2 3 4 5 6 7 8 9 10

WHAT DO YOU FEEL IS THE CAUSE OF YOUR HEADACHES? _____

DOES YOUR HEADACHE AFFECT YOUR VISION? Y N

DOES YOUR HEADACHE AFFECT YOUR HEARING? Y N

DOES YOUR HEADACHE AFFECT YOUR BALANCE? Y N

DO YOU FEEL NUMBNESS IN ANY PART OF YOUR BODY? Y N EXPLAIN:

DOES YOUR HEADACHE EVER WAKE YOU UP? Y N

WHAT DOCTORS HAVE YOU SEEN AND WHEN FOR THIS CONDITION?

WHAT MEDICAL TESTING HAS BEEN DONE AND WHEN? _____

WHAT TREATMENT HAS BEEN GIVEN AND WHAT RESULTS DID YOU HAVE? _____

WHAT MEDICATIONS ARE YOU TAKING FOR HEADACHES AND DO THEY HELP?

_____ Y N _____ Y N

_____ Y N _____ Y N

_____ Y N _____ Y N

LIST ANY OTHER MEDICATIONS: _____

WHAT TYPE OF PILLOW DO YOU SLEEP ON? _____

WHAT IS YOUR USUAL SLEEP POSITION? _____

HOW MANY HOURS OF SLEEP DO YOU GET? _____

DO YOU SUFFER FROM DEPRESSION? Y N

DO YOU SMOKE? Y N HOW MUCH? _____

WHAT IS YOUR ALCOHOL CONSUMPTION? _____

DO YOU HAVE ANY PROBLEMS WITH YOUR JAW JOINT? Y N

HAVE YOU RECENTLY HAD DENTAL WORK DONE? Y N EXPLAIN: _____

IS THERE ANY OTHER INFORMATION THAT YOU CAN TELL US THAT WOULD HELP US TO HELP YOU?

