WMC Health | Westchester Medical Center
Westchester Medical Center Health Network

Headache Questionnaire

Westchester Medical Center Headache Specialists

ONSET

1. At what age did you begin suffering from headaches?

☐ As a child ☐ As a teenager ☐ In my 20's – 40's ☐ In my 50's – 60's

When were your headaches their worst?

2. When did your current headache problem begin? ☐ Months / ☐ Years / ago.

3. Precipitating event: Was there a precipitating event or trigger for your current headache problem?

☐ None known ☐ Motor vehicle accident ☐ Birth control pill ☐ Other
☐ Specific stress ☐ Illness ☐ Pregnancy
☐ Injury ☐ Menarche ☐ Hormone replacement

HEADACHE CHARACTERISTICS

4. Frequency of headache: On average how often do you have a headache?

They occur: times each... ☐ Day ☐ Week ☐ Month

Are they increasing in frequency? ☐ Yes ☐ No

They are more frequent on: ☐ Weekdays ☐ Weekends ☐ Spring ☐ Summer ☐ Fall ☐ Winter

5. Onset of each headache:

Headaches typically begin: ☐ Gradually ☐ Suddenly ☐ Varies

They usually begin in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

How long before they reach maximal intensity? ☐ Minutes ☐ Hours

6. Duration of the headaches:

Headaches usually last (with medication) ☐ Minutes ☐ Hours ☐ Days

Headaches usually last (without medication) ☐ Minutes ☐ Hours ☐ Days

7. Intensity of the headaches:

With medication: ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating

Without medication:: ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating

Headaches prevent activities: ☐ School ☐ Work ☐ Household chores

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HEADACHE CHARACTERISTICS / *continued...*

8. Location of headaches: Where do you feel the pain during your headaches?

- ☐ Left side
- ☐ Forehead
- ☐ Right side
- ☐ Temple
- ☐ May be either side
- ☐ Behind eye(s)
- ☐ Both sides
- ☐ Back of head
- ☐ Neck
- ☐ Other

9. Pain Type: What does the headache pain feel like?

- ☐ Pressure
- ☐ Stabbing
- ☐ Throbbing
- ☐ Tight band
- ☐ Burning
- ☐ Dull ache
- ☐ Other

10. Headache Triggers: Do any of the follow bring on/trigger your headaches?

- ☐ Foods
- ☐ Too much caffeine
- ☐ Hunger/skipping meals
- ☐ Fatigue
- ☐ During stressful times
- ☐ Menstruation
- ☐ Exercise
- ☐ Prolonged computer work
- ☐ Certain Odors
- ☐ Not getting enough caffeine
- ☐ Alcohol
- ☐ Too little sleep
- ☐ After stress (first day of vacation, weekend, after a test)
- ☐ Sexual activity
- ☐ Weather changes
- ☐ Bright lights/sun
- ☐ Wine
- ☐ Too much sleep
- ☐ Coughing
- ☐ Loud sounds

11. How painful are your migraine headaches? (Check one number)

MILD... ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ...SEVERE

12. Premonitory Symptoms: Do you experience any of the following before your headache begins?

- ☐ Mood changes
- ☐ Change in appetite
- ☐ Neck pain
- ☐ Personality changes
- ☐ Food cravings
- ☐ Fatigue
- ☐ Other
- ☐ None of these symptoms

13. Aura Symptoms: Do you experience any of these warning symptoms before your headache begins?

- ☐ Bright lights/flashes of lights/ multi-colored lights
- ☐ Zig-zag lines
- ☐ Numbness/tingling
- ☐ Dizziness or vertigo
- ☐ Partial loss of vision/blurry vision/blindness
- ☐ Paralysis
- ☐ Upset stomach/nausea
- ☐ None of these symptoms

14. Associated Symptoms: Do you experience any of these symptoms during your headaches?

- ☐ Nausea/upset stomach
- ☐ Bright lights/sun bothers you
- ☐ Strong smells/odors bother you
- ☐ Dizziness/lightheadedness/ vertigo
- ☐ Numbness or tingling
- ☐ Increased sensitivity of scalp/hair/ears
- ☐ Eye tears
- ☐ Difficulty concentrating
- ☐ Vomiting
- ☐ Loud sounds bother you
- ☐ Runny or stuffy nose
- ☐ Mood changes/irritability

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HEADACHE CHARACTERISTICS / *continued...*

15. Alleviating Factors: During a headache, what makes you feel the most comfortable?

- ☐ Lying down/sleeping
- ☐ Keeping physically active
- ☐ Massage your head
- ☐ Cold pack on your head/neck
- ☐ Being in a dark quiet rom
- ☐ Pacing back and forth
- ☐ Tying something around your head
- ☐ Hot pack on your head/neck

HEADACHE-RELATED DISABILITY

16. Effect of headaches on ability to function:

a) During milder headaches:

- ☐ I am able to function normally
- ☐ My ability to function is slightly decreased
- ☐ My ability to function is severely decreased
- ☐ I am totally bedridden

b) During moderate or severe headaches:

- ☐ I am able to function normally
- ☐ My ability to function is slightly decreased
- ☐ My ability to function is severely decreased
- ☐ I am totally bedridden

17. Doctor Visits for Headache: How many times would you estimate that you have visited the following because of your headaches in the past year?

Family physician: _____ Walk in clinic: _____ Emergency department: _____

18. How many days of work or school have you missed in the past 1 year because of headaches? _____

HEADACHE RELATED INVESTIGATIONS

19. Previous Testing: Have you had any of the following tests done to investigate your headaches? If yes, please indicate the approximate date and results:

- ☐ CAT scans _____
- ☐ EEG _____
- ☐ Neck x-rays _____
- ☐ MRI _____
- ☐ Sinus x-rays _____
- ☐ Other _____

20. Previous Consultations: Have you seen any of the following about your headaches? If yes, please give the name and approximate date:

- ☐ Neurologist _____
- ☐ Dentist _____
- ☐ Pain Clinic _____
- ☐ Internal medicine _____
- ☐ Ear, nose and throat specialist _____
- ☐ Psychiatrist _____
- ☐ Eye doctor _____
- ☐ Allergy specialist _____

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HEADACHE-SPECIFIC TREATMENT

21. Multi-Disciplinary Health Care: Have you seen any of the following about your headaches?

- Chiropractor
- Physiotherapist
- Naturopath/homeopath/ herbalist
- Nutritionist
- Psychologist
- Massage therapist
- Acupuncturist
- Other

22. Headache Related Purchases: Have you purchased any of the following to try to treat your headache?

- Hot packs
- Aromatherapy
- Herbs/ herbal supplements
- Other
- Cold packs
- Naturopathic medicines
- Anti-inflammatory rubs
- Eye masks
- Headache self-help book
- Mouth-guard

23. Headache Relief from Medications: How long does it take before you become pain-free after taking your current headache medications?

- Within 1 hour
- 1 – 2 hours
- >2 hours
- I never become pain–free after medication

24. Current Headache Medications: Please include all over the counter and prescription medications / pain relievers that you are currently using to treat your headaches:

Medication name & dose:

Average & maximum used in 1 day:

How many days used per month:

Side effects:

% of time effective:

End of Form.