*** For each question, check all the boxes that apply to you (ie you may check more than 1 box)
ONSET 1. Did you suffer from headaches when you were younger? □ As a child □ In my 20's – 40's □ As a teenager □ In my 50's or 60's
When were your headaches at their worst? _____

2. When did your current headache problem begin? Headaches became a problem _____ Months □ Years □ ago.

3. Precipitating Event - Was there a precipitating event or trigger for your current headache problem? □ None known □ Specific stress _____ □ Injury _____ □ Motor vehicle accident _____ □ Illness _____ □ Menarche (first period) □ Pregnancy □ Birth Control Pill □ Hormone Replacement □ Other _____

HEADACHE CHARACTERISTICS: 4. Frequency of headaches - On average, how often do you have headaches? 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 - How bad are your headaches? With medication: □ Mild □ Moderate □ Severe □ Incapacitating Without medication □ Mild □ Moderate □ Severe □ Incapacitating Headaches prevent activities □ School □ Work □ Household chores

8. Location of Headaches - Where do you feel the pain during your headaches? □ Left side □ Right side □ May be either side □ Both sides □ Other _____ □ Forehead □ Temple □ Behind eye(s) □ Back of head □ Neck 9. Pain Type - What does the headache pain feel like? □ Pressure □ Stabbing □ Throbbing □ Other _____ □ Tight band □ Burning □ Dull ache 10. Headache Triggers - Do any of the following bring on/trigger your headaches?
□ Foods (specific food triggers will be discussed later in the questionnaire) □ Too much caffeine □ Not getting enough caffeine □ Hunger / Skipping meals □ Alcohol □ Wine □ Fatigue □ Too little sleep □ Too much sleep (sleeping in) □ During stressful times □ After stress (first day of vacation, weekend, after a test) □ Menstruation □ Exercise □ Sexual activity □ Coughing □ Prolonged computer work □ Weather changes □ Certain Odors □ Bright lights/sun □ Loud sounds Other
_____

11. Premonitory Symptoms - Do you experience any of the following before your headache begins? □ Mood changes □ Personality changes □ Other _____ □ Change in appetite □ Food cravings □ Neck pain □ Fatigue □ No, I don't experience any of these 12. Aura Symptoms - Do you ever experience any of these warning symptoms before your headache begins? □ Bright lights / flashes of lights/ multi-colored lights (circle applicable description) □ Zig-zag lines □ Partial loss of vision / blurry vision / blindness (circle applicable) □ Numbness / tingling □ Paralysis □ Dizziness or vertigo □ Upset stomach / nausea □ No I don't have these 13. Associated Symptoms - Do you experience any of these symptoms during your headaches? □ Nausea / upset stomach □ Vomiting □ Bright lights/sun bothers you □ Loud sounds bother you □ Strong smells/odors bother you □ Dizziness / lightheadedness / vertigo (circle applicable description) □ Numbness or tingling □ Increased sensitivity of Scalp / Hair / Ears □ Eye tears □ Runny or stuffy nose □ Difficulty concentrating □ Mood changes / irritability

14. Alleviating Factors - During a headache, what makes you feel the most comfortable? □ Lying down / sleeping □ Being in a dark quiet room □ Keeping physically active □ Pacing back-and-forth □ Massage your head □ Tying something around your head □ Cold pack on your head/neck □ Hot pack on your head/neck

15. Effect of headaches on ability to function: a) During Milder headaches: b) During moderate or severe headaches: □ I am able to function normally □ I am able to function normally □ My ability to function is slightly decreased □ My ability to function is slightly decreased □ My ability to function is severely decreased □ My ability to function is severely decreased □ I am totally bedridden □ I am totally bedridden

16. Doctor Visits for Headache – How many times would you estimate that you have visited the following because of your headaches in the past 1 year? □ Family physician _____ □ Walk-in clinic _____ □ Emergency department _____

17. How many days of work or school have you missed in the past 1 year because of headaches? _____
18. What diagnostic testing have you pursued for your headaches? CAT Scan, MRI, EEG, Sinus X-rays, Neck X-rays, Other
19. Previous Consultations-Have you seen any of the following about your headaches? Neurologist, ENT (Ears, Nose and Throat specialist), Dentist, Psychiatrist, Pain Clinic, Eye Doctor, Internal Medicine, Allergy Specialist, Chiropractor, Acupuncturist, Nutritionist, Massage Therapist, Naturopath (homeopath, herbalist), Psychologist, Physical Therapy?
20. Please current headache medication and list their efficacy (according to 1 to 5 level)
21. Please list alternate, non-pharmaceutical treatments attempted: i.e. ice packs, essential oils, herbal products, etc.