TEXAS NEUROLOGY

HEADACHE QUESTIONNAIRE I

NAME: _____ **DATE:** _____

Where do you generally experience your headache(s)?

❍ Left side ❍ Right side ❍ Either side ❍ Orbital ❍ Hatband
❍ Frontal ❍ Face/Jaw ❍ Neck ❍ Generalized ❍ Moves around

What type of headache do you experience?

❍ Achy ❍ Lightning bolts ❍ Pulsating ❍ Throbbing ❍ Pounding ❍ Crushing
❍ Piercing ❍ Sharp ❍ Deep pain ❍ Squeezing ❍ Dull ❍ Pressure

When do your headaches generally occur?

❍ Morning ❍ Afternoon ❍ Evening ❍ Middle of the night ❍ Menstrual ❍ Constant

How severe are your headaches?

❍ Mild ❍ Moderate ❍ Severe

When did your headaches first start?

❍ Childhood ❍ Teens ❍ 20s ❍ 30s ❍ 40s ❍ 50s ❍ 60s+

How are your headaches relieved?

❍ Rest ❍ Quiet and darkness ❍ Cold compress ❍ Ice
❍ Heat ❍ Massage ❍ Pressure over area ❍ Medications

What worsens or triggers your headaches?

❍ Medications ❍ Coughing ❍ Sneezing ❍ Heat/Sun ❍ Missing meals
❍ Smoke ❍ Talking ❍ Alcohol ❍ Weather ❍ Exercise
❍ Sexual activity ❍ Under sleeping ❍ Bending ❍ Lying down ❍ Certain foods
❍ Cold ❍ Fatigue ❍ Menstruation ❍ Smells/Odors ❍ Stress

What are the associated symptoms?

❍ Light sensitivity ❍ Joint pain ❍ Sound sensitivity ❍ Visual changes ❍ Muscle spasm ❍ Nasal congestion
❍ Smell sensitivity ❍ Neck pain ❍ Difficulty speaking ❍ Red teary eye ❍ Queasiness ❍ Limits activity
❍ Dizziness, vertigo, lightheadedness ❍ Nausea and/or vomiting
❍ Numbness or tingling of body part ❍ Weakness of body part

Have you tried any of the following to treat your headaches?

❍ Biofeedback ❍ Acupuncture ❍ Physical therapy ❍ Therapeutic massage
❍ Chiropractic therapy ❍ Nerve stimulator ❍ Nerve blocks

Have you had any previous head injury?

❍ Yes ❍ No

Have you had a recent eye exam within the past 3 months?

❍ Yes ❍ No