Spine & Sport Biomechanical Rehabilitation Center Headache Questionnaire

Patient Name: ____ **DOB:** _____________ **Date:** _____________

Please answer the following questions to the best of your ability regarding your headaches:

When did your headaches start? _____ days ago _____ weeks ago _____ months ago _____ years ago

Did your headache start after an injury? □Yes □ No If yes, describe: ____

Did your headache start after an illness? □Yes □ No If yes, describe: ____

Did your headache begin when you started/changed medication? □Yes □ No If yes, what medication? _________________

How many days in a month do you have a headache? __________ **How many headache-free days in a month?**__________

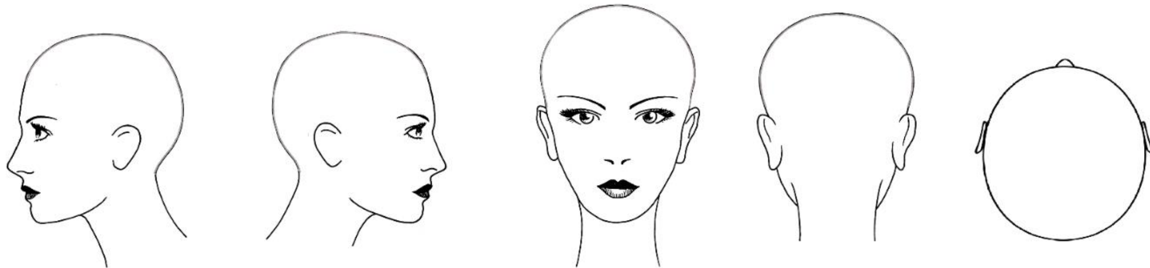
How severe are your headaches? (0 to 10 = worst pain possible): **Range:** 1 2 3 4 5 6 7 8 9 10 **Average Pain:** ______ / 10

Do you have more than one type of headache? □**Yes** □ **No** *If yes, focus the following questions on your* *worst* *headache type.*

Where are your headaches located in general? (check all that apply)

□ Temple: R / L □ Front of head □ Top of head: R / L □ Ear: R / L □ Jaw
□ Back of head: R / L □ Around head □ Neck □ Eye: R / L □ Other: ____________________

Please indicate on the diagram below where you experience your headaches:



Your headaches usually feel: (check all that apply)

□ Throbbing □ Pulsing □ Dull □ Tight □ Shooting □ Other: _______________
□ Achy □ Stabbing □ Burning □ Pressure □ Other: ___________ □ Other: _______________

How long do your headaches last in HOURS? Shortest _____ Longest ____ Average _____ or are they constant? □Yes □ No

Your headaches are worse in the: □ morning □ afternoon □ evening □ during the night □ no pattern Other: _____________

Are your headaches worse: □Lying down □ Standing □ Sitting □ At rest □ With activity Explain: _________________________

Do you experience one or more of these symptoms 1 to 2 days **before** **onset of a headache:**

□ Hyperactive □ Difficulty with speech □ Food cravings □ Excessive yawning
□ Depressed feeling □ Sensitive to light □ Increased appetite □ Stiff neck
□ Irritability □ Sensitive to sound/noise □ Decreased appetite □ Difficulty concentrating
□ Feeling sluggish □ Dizziness □ Increased urination □ Other: ___________________________

Aura: (Do you have these symptoms before your headache begins?)

□ Flashing lights □ Loss of vision in one eye □ Tunnel vision □ Spots: bright/dark
□ Speech difficulty □ Geometric forms □ Double vision □ Numbness/tingling
□ Distorted vision □ Total blindness □ Wavy lines □ One-sided weakness (Right / Left / Both)
□ Light headedness □ Vertigo □ Dizziness □ Confusion/déjà vu/hallucinations

If you have any of these symptoms above, they usually last:

□ _______ minutes □ The duration of the headache □ Other: ____

Please check the symptoms you experience <u>during</u> your headache? (mark all that apply)

□ Nausea or upset stomach/vomiting
□ Sensitivity to light (prefer a dark room)
□ Sensitivity to sound (prefer a quiet room)
□ Sore/stiff neck
□ Vision changes (blurred, spots, patterns)
□ Eye tearing
□ Runny nose
□ Diarrhea / Constipation
□ Stroke like symptoms (facial droop, droopy eye lid, unable to move arm or leg)
□ Sensitivity to smells
□ Ringing in ears
□ Increased appetite
□ Decreased appetite
□ Anxiety
□ Irritability
□ Memory problems
□ Dizziness/vertigo
□ Confusion
□ Difficulty thinking/concentrating/focus
□ Difficulty speaking/slurred speech
□ Increased Urination
□ Eye-redness (Right / Left / Both)
□ Drooping eyelid (Right / Left / Both)
□ Swelling of eyelid (Right / Left / Both)
□ Sleepiness
□ Numbness/Tingling Where? ___________

Please check any triggers, things that bring on a headache

Food/beverage: □ Fasting □ Skipping meals □Chocolate □ Caffeine □ Nitrates □ MSG □ Aged cheese □ Alcoholic drinks
Physical exertion: □ Coughing □ Talking □ Chewing □ Exercise □ Sexual intercourse
Hormonal: □ Menses (□ Before □ During □ After) □ Pregnancy □ Menopause □ Stress □ Environmental: Allergies
Weather changes: □ Altitude □ Sunlight □ Rain □ Cold Temps □ Warm Temps □ Other: ________________________________
Sleep: □ Lack of sleep □ Too much sleep □ Change in wake/sleep □ Other: ____

Activity that worsens headache: □ None □ Walking □ Climbing Steps □ Exercise □ Other: ____________________________

Relieving Factors

□ Lying down □ Dark quiet room □ Hot compress □ Massage □ Other: ______________________
□ Standing □ Ice/cold compress □ Keeping active/pacing □ Pregnancy □ Other: ______________________

Which medications/treatments have you tried to stop a headache? ____
____
____

Have you had brain and/or cervical spine MRI or CT? □Yes □No **Have you had lumbar puncture (spinal tap)?** □ Yes □ No

Have you needed to go to the hospital / ER for headaches? □ Yes □ No If yes, how many times in the last 6 months? ______

Have you been treated in an infusion clinic for your headaches? □ Yes □ No If yes, how many times in the last 6 months? ____
Procedures used: □ Occipital nerve blocks □ Auriculotemporal nerve blocks □ Botox injections □ Other procedures __________

Exercise: How often do you exercise? _____ / days per week What type of exercise? __________________________________

How many hours do you sleep a night? __________/ hours
Do your headaches wake you up during the night? □Yes □ No If yes, how often? __________________________________
Do you have any problems staying asleep? □Yes □ No **Do you have any problems falling asleep?** □ Yes □ No
Do you snore? □Yes □ No **Do you have sleep apnea?** □ Yes □ No **Do you grind your teeth?** □ Yes □No

Thinking back to the last 3 months (90 days):

On how many days did you miss work or school because of your headaches? ____________________________________ □ N/A

On how many days did you not do household work because of your headaches? ______________________________________

On how many days did you miss family, social, or leisure activities because of your headache? ___________________________

Anything else you would like us to know regarding your headaches: ____
____
____
____
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