Name:______________________________ Date:____________

Please circle the response that best describes how you feel and calculate the totals below.

1. When you have headaches, how often is the pain severe?

A) Never B) Rarely C) Sometimes D) Very Often E) Always

2. How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

A) Never B) Rarely C) Sometimes D) Very Often E) Always

3. When your have a headache, how often do you wish you could lie down?

A) Never B) Rarely C) Sometimes D) Very Often E) Always

4. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

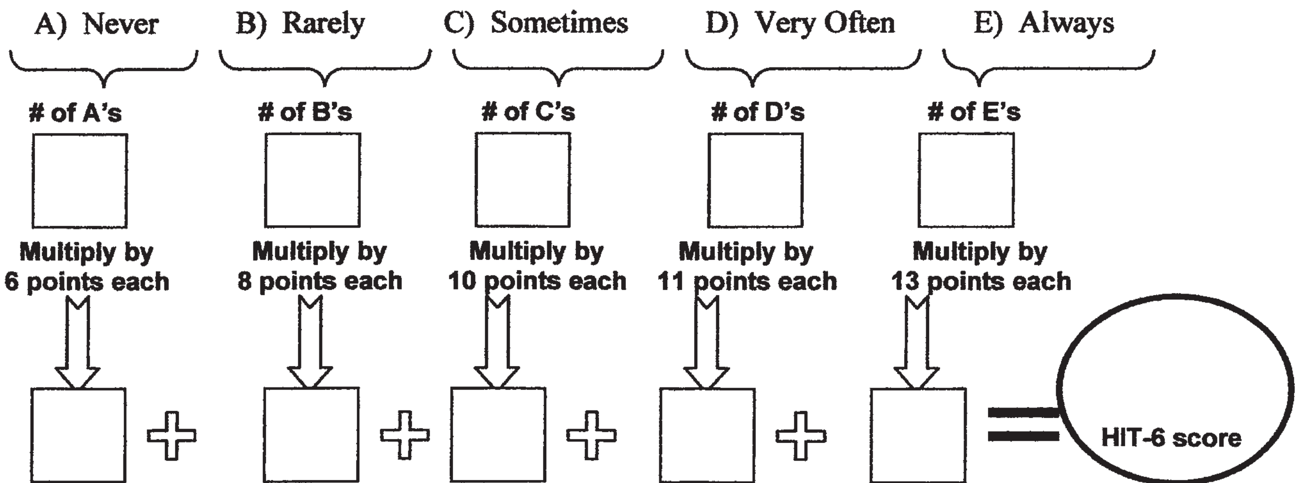
A) Never B) Rarely C) Sometimes D) Very Often E) Always

5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

A) Never B) Rarely C) Sometimes D) Very Often E) Always

6. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

A) Never B) Rarely C) Sometimes D) Very Often E) Always



Bonus Questions

On a scale of 0-10, with "10" being the worst discomfort imaginable above the shoulders, and a "0" is no pain at all (you feel fabulous), how many mornings per week do you wake with a "0", that is, *you feel fabulous?*_______

On those mornings that you wake "with a number", what's the average number that you have? _______

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Headache History Questionnaire

1. On a scale of 1-10, with "10" being the worst pain imaginable above the shoulders, how many mornings per week do you wake with a "0" (zero)? ____
2. On a scale of 1-10, what's the average "number" you usually wake with? ____
3. What % of your ***waking*** time do you have some degree of headache? ____
4. What % of your ***waking*** time do you have a "0" (zero) without taking medications? ____
5. What is your average headache pain level (1-10 scale) throughout the day? ____
6. On a scale of 1-10, what is the worst pain level you experience? ____
7. What time of day do you usually experience your worst headaches? ____
8. How many times per week (or month) might you experience your worst pain? ____
9. Where does your pain seem to originate from?

   ____

10. How would you describe your pain? (examples: throbbing, squeezing, pressure, dull, stabbing, shooting, etc.)

    ____

11. Please circle the types of health care providers you've seen for your headaches.

    MD Neurologist ENT Internist Physical Therapist Chiropractor Dentist

    Others: ____________________

12. What medical tests have been performed regarding your headaches?

    CT scan MRI Xray Blood analysis Other: ____________

13. What types of procedures or treatments (including dental) have you had regarding your headaches?

    ____

14. What medication(s) do you now take to prevent your headaches?

    ____

15. What medications have you tried to prevent your headaches?

    ____

16. What prescription or over-the-counter medications do you take to relieve you headaches? (and how much)

    ____

Shade in the areas below where you experience your discomfort