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Patient's Last Name . . . . First Name . . . .

Age: . . . . . Date of Birth: . . . / . . . / . . . **Date: … / . . . / . . .**

Month Day Year

HEADACHE Questionnaire

When did the headache start first time?	
How many times per week you get it?	
The pain is	_ *stronger on* week**days** _*less on* week**ends** _*no difference*
Do you have more than one type of headaches?	
On the scale from "1" to "10" your ***average*** headache is:	1 2 3 4 5 6 7 8 9 **10**
On the scale from "1" to "10" your ***strongest ever*** headache was:	1 2 3 4 5 6 7 8 9 **10**
Do you have to stop your activity and lie down when you get a headache?	_yes _no
How many days missed from school (work) for the last month due to headache?	. . .
What time during the day you get a headache?	_*afternoon* _*evening* _morning _…
A typical attack lasts	_*30 min or less* _*up to one hour* _*up to 3-4 hours* _…
Does sleep or rest help?	_yes _no
Where in the head it hurts?	_*In the front* _*In the back of head* _*in temples* _ …
Which side in the head it hurts?	_*Left side* _*Right side* _*Rather diffusely* _…
The most typical pain feels like	_*dull pressure, squeezing* _ *pounding* _…
The pain is provoked by	_*by fatigue* _*by stress* _ *noise, odor…* _*certain foods*
Do you get any warning signs that the headache is going to start?	
When your are in pain, does the bright light aggravate?	_yes _no
When your are in pain, does the noise aggravate?	_yes _no
Do you have nausea with the headache? _yes _no	Vomiting? _yes _no
Which medication do you take during the headache?	1) 2) 3)
Does it help? _yes _no	
Who else from the family also suffers (suffered) from headaches?	