Headache Questionnaire
Please fill this out, print a copy and bring it to your appointment

Age: _____Sex:_____ ☐ Right handed or ☐ Left handed Height: _____ Weight: _____

What do you want to accomplish from this consultation? _____

Headache History

1. At what age did you **START** having headaches? _____

2. At what age did headache become a **BOTHERSOME** symptom in your life? _____
   a. What do you think triggered it? (Ex: head injury, medication change, new medical diagnoses, change in weight, habit, lifestyle routines, financial, work, home, psychological stress) _____
   b. Bothersome as in ☐ stronger ☐ lasting longer ☐ occurring more frequently

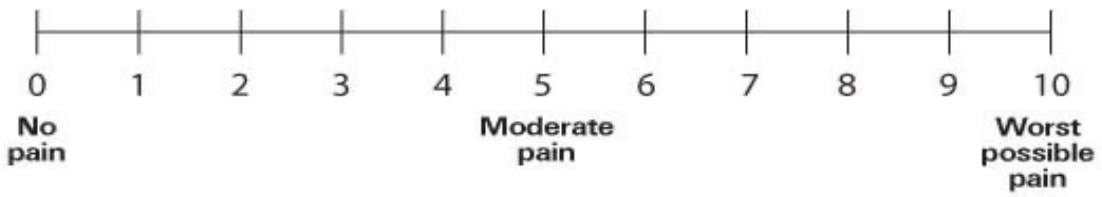
3. On average, how many days within a month (out of 30 days) are you bothered by **ANY** degree of headache (including headache pressure, sinus pain, upper neck pain)
   a. Out of the days identified, how many days would be considered **moderate to severe in severity** (meaning you have to take medications, or your day to day routines are affected)? _____
   b. If you have a headache everyday, do you have pain-free moments? ☐ Yes ☐ No If so, how long? _____
   c. How **LONG** did it take to become this pattern? _____
   d. How **LONG** does your headache last for? _____
   e. Do your headaches occur on any particular day of the week or time of day? _____

4. How would you describe the pain of your **most serious headaches**? (circle all that apply)

   throbbing *pulsating* *dull* *aching* *pressure-like*
   sharp *stabbing* *electric-like* *vise-like*

   If not on the list, please describe _____

5. What is the average pain intensity of your headache on a scale of 0-10?



   a. How long does it take for your headache to reach maximum intensity? _____

6. Do you have a **WARNING SIGN (Aura)** before a headache? ☐ Yes ☐ No
   a. If you experience visual disturbance as a warning sign: **(Check/circle all that apply):**
      1. Duration (How long?): _____
      2. Develops gradually over or greater than 5 minutes ☐ Yes ☐ No
      3. ☐ zig-zag lines, ☐ losing parts of your visions, ☐ tunnel vision ☐colours
         a. Others: _____
      4. How long after you experience these symptoms before your headache kicks in? _____
   b. If other warning signs, please describe: _____

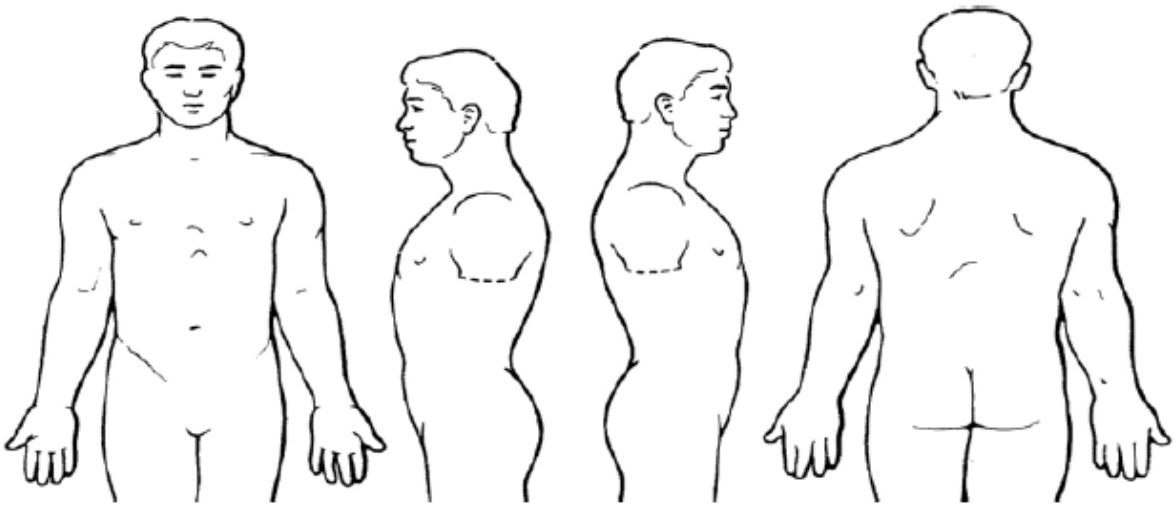
7. Are your headaches brought on by: **(circle all that apply):**

your periods / hormonal changes *exercise* *stress* *relaxation after stress* *change in weather*
alcohol *bright light / glare* *odors* *smoke* *noise* *lack of sleep* *too much sleep* *hunger*
food additives *certain foods*

Pain Location

Mark on the drawing below the exact spot where your pain is located. Use a solid black dot (□). If the pain starts at that spot and radiates elsewhere (travels to another part of your body), draw a line from the spot where the pain starts to where it ends. If it is a whole area that hurts, shade in that area with a pencil.

Next to the places on the drawing where you showed pain, put an "E" if the pain is external (on the outside surface). If the pain is internal (inside the body) mark it with an "I." If the pain is both internal and external, mark "EI."



Right **Left** **Left** **Right**

8. Do you experience the following with your headaches? **(Check all that apply)**:
   ☐ nausea ☐ vomiting ☐ light sensitivity ☐ sound sensitivity ☐ smell sensitivity

9. With your headaches, do you experience tearing of the eyes, runny nose, nasal congestion, ear fullness **ONLY** and EVER on one side of the face? ☐ Yes ☐ No if yes: Please describe _____

10. Does your headache get significantly worse upon sitting or standing up? if yes: Please describe _____

11. Does straining, such as coughing or sneezing triggers a headache (Please check no if it only worsen the headache) if yes: Please describe _____

12. Aside from headache, are you bother by the following **(Check all that apply)**:
    a. ☐Ringing in the ears ☐ room spinning sensation ☐brain fog ☐neck tightness/pain

Family History: Do any of your family members have headaches or migraine? If so: please indicate

Lifestyles:

1. What time do you go to sleep and wake up? Weekdays:_____Weekends:_____
2. How long does it take you to fall asleep? _____
3. Do you have any sleep disturbance? ☐ Yes ☐ No
    a. If so, why? **(Check all that apply):**
        i. ☐ Difficulty falling asleep ☐ waking up multiple times ☐waking up too early ☐snoring ☐sleep apnea ☐ uses CPAP
4. Do you sleep at the same time on weekdays and weekends? ☐ Yes ☐ No
5. How often do you do aerobic exercise per week? (running, biking, elliptical, swimming) _____
    a. If so, how long each time? _____
    b. Does your headache get better after exercise? ☐ Yes ☐ No
    c. Does your headache get worse during exercise? ☐ Yes ☐ No
6. Do you eat regular meals? ☐ Yes ☐ No
    a. Specific dietary plan? (Ex: Ketogenic, Gluten free, intermittent fasting) _____

Social History:

1. Do you smoke? ☐ Yes ☐ No if yes (How often, how much) _____
2. Do you drink? ☐ Yes ☐ No if yes (How often, how much) _____
3. Do you use cannabis?☐ Yes ☐ No if yes (How often, how much) _____
4. Do you use other illicit drugs ☐ Yes ☐ No if yes (How often, how much) _____
5. What is you current level of stress (0 = no stress, 10 = catastrophic): _____
6. Present work/school status: _____
7. If you have children, please list their ages _____
8. Hobbies / recreational activities: _____

For FEMALE patients only:

1. Do you get a headache around your period? ☐ Yes ☐ No
2. Are you on any forms of contraception? ☐ Yes ☐ No If so: what formulation is it? _____
3. Is there a plan for pregnancy in the next 1-2 years? ☐ Yes ☐ No

Current Medications

Medications - List all you are currently taking and dosages (prescriptions, over the counter, herbal):

Medication	Dose	Frequency	Date Started	Prescribing Doctor

Are you getting treatments from the following healthcare professionals? (Circle all that apply)
Psychologist Psychiatrist Chiropractor Physical therapist Massage therapist Acupuncturist

Drug Allergies: _____

Past Medications: Which of the following medicines have you tried in the PAST

Rescue/Acute/Abortive Medications			
Over the counter medications			
Medication (Circle all that apply)	**Dosage**	**Start date & Timeframe (How long did you take it for?) (month/year)**	**Why stopped? Please explain**
Acetaminophen (Tylenol) Ibuprofen (Advil, Motrin) Naproxen (Aleve) Aspirin Diclofenac			
Prescriptions			
Almotriptan (Axert) Eletriptan (Relpax) Frovatriptan (Frova) Naratripan (Amerge) Rizatriptan (Maxalt) Sumatriptan (Imitrex) Zolmitriptan (Zomig)			
Dihydroergotamine (DHE)			
<u>Opioids</u> Tramadol Codeine Percocet Oxycodone Fentanyl Morphine Codeine			
Preventive medication: (Medication you take daily to help prevent headache frequency			
<u>Blood pressure medications</u>			

Medication (Circle all that apply)	Dosage	Start date & Timeframe (How long did you take it for?) (month/year)	Why stopped? Please explain
Blood pressure medications (Antihypertensives)			
Metoprolol Propranolol (Inderal) Lisinopril Nadolol Candesartan Flunarizine Other: _____			
Anti-seizure			
Topiramate (Topamax) Divalproex sodium (sodium valproate) (Depakote) Gabapentin (Neurontin) Pregabalin (Lyrica) Other: _____			
Antidepressants			
Amitriptyline (Elavil) Nortriptyline (Palmelor) Venlafaxine (Effexor) Duloxetine (Cymbalta) Benzodiazepine (such as lorazepam, alprazolam, clonazepam Other: _____			
Supplements			
Other supplements Magnesium Coenzyme Q10 Vitamin B2 Butterbur (petadolex) Feverfew			

Past Medical History Have you had any of these conditions either now or in the past? ***Please check YES or NO***

Yes	No		Yes	No	
		Heart:			**Lungs:**
		High blood pressure			Bronchitis
		High cholesterol			Asthma
		Angina			Shortness of Breath
		Heart attack			**Liver / Kidneys:**
		Congestive cardiac failure			Hepatitis
		Cardiac surgery			Liver problems
		Irregular heart beat			Kidney problems
		Nervous system:			Bladder problems
		Seizures			**Metabolic / Digestive:**
		Stroke			Diabetes: Insulin or Non-Insulin Dependent?
		Paralysis			Thyroid disease
		Peripheral neuropathy			Acid reflux
		Musculoskeletal:			Stomach ulcer
		Arthritis			**Cancer:**
		Neck/back problems			Site:
		Artificial joints (replacement)			**Alcohol/Drug Dependency or Addiction**
		Other:			List:
		Blood Disorder:			**Psychological/Psychiatric:**
		Anemia			Depression/Anxiety
		Bruising			Panic Disorder
		Bleeding Problems			Post-Traumatic Stress Disorder
		Immune Disorder:			**Other Medical Problems (Please Describe):**
		HIV			
		Other:			

1. Have you suffered any head injuries before? ☐ Yes ☐ No If yes, describe:(Who, What, When, Where, How, legal litigation, WSIB, disability)

2. As a child, did you suffer from vertigo, abdominal pain, vomiting, car sickness, or any form of abuse? ☐ Yes ☐ No

If yes, please explain:

Surgical History

Have you had any surgeries directly related to your pain problem(s)? YES NO (If yes, please complete the information below)

Name and year of surgery (i.e. lumbar fusion, abdominal surgery)

1.		Year:
2.		Year:
3.		Year:
4.		Year:
5.		Year:

Have you had other surgeries that weren't related to your pain? (e.g., appendectomy, tonsillectomy) '
YES NO (If yes, please complete the information below)
Name and year of surgery

1.		Year:
2.		Year:
3.		Year:
4.		Year:
5.		Year:

Diagnostic Tests

List any diagnostic tests (i.e. MRI, XRAY, EMG, etc.) you have had related to your pain problem including dates and results:

Date	Exam	Where performed	Results

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you. **INSTRUCTIONS:** Please answer the following questions about all of your headaches over the last 3 months. Write your answer in the box next to each question. Write zero if you did not do the activity in the last 3 months.

1. _____ On how many days in the last 3 months did you miss work or school because of your headaches? (if you do not attend work or school enter zero.

2. _____ How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school, enter zero).

3. _____ On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?because of your headaches?

4. _____ How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

5. _____ On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?

6. _____ **Scoring:** After you have filled out this questionnaire, add the total number of days from questions 1-5

MIDAS Grade	Definition	MIDAS Score
I	Little or No Disability	0-5
II	Mild Disability	6-10
III	Moderate Disability	11-20
IV	Severe Disability	21+

PHQ-4: **The 4 item**

patient health questionnaire for anxiety and depression

Over the last two weeks, how often have you been bothered by the following problems?	**Not al all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious or on edge	**0**	**1**	**2**	**3**
No being able to stop or control worrying	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**

- Normal (0-2), mild (3-5), moderate (6-8), severe (9-12)
- Total score >3 for first 2 questions suggests anxiety
- Total score >3 for last 2 questions suggests depression