Patient's Name: **Date:**

1- How old were you when you started having headaches?

2- Do any of your family members have headaches?

_____Mother _____Father _____Brother(s) _ _Sister(s) _____Children

3- How often do the headaches occur?

4- How often do you miss school or work because of a headache?

5- How long does your headache last on average?

6- Do your headaches always occur at a certain times of the day? (morning, afternoon, night)

7- Are the headaches becoming stronger, lasting longer or occurring more frequently?

8- Do the headaches ever wake you up from sleep?

9- Are your headaches worse lying down and better upright?

10- Where is the headache located?

_ _Left side _ _Right side _ _Both sides
_ _Neck _ _Forehead _ _All around the head _ _Temples
_ _Top of the head _ _Back of the head

For other locations (please describe):

11- What does the pain feel like?

_ _Throbbing or pounding (like a hammer)
_ _Tightness (like a rubber band wrapped around the head)
_ _Pressure _ _Dull _ _Aching _ _Sharp

Describe the pain in your own words if different:

12- What makes your headache worse?

13- What helps alleviate your headaches?

14- Are there any other symptoms associated with the headache?

_ _Nausea _ _ Vomiting _ _ Intolerance to lights _ _Intolerance to sounds
_ _Weakness in the arms or legs _ _ Numbness in the arms or legs
_ _Runny nose _ _Tearing eyes _ _Red eyes _ _Droopy or swollen eyelids
_____Loss of vision or double vision

15- Is your headache worse with activity?

16- Do you have any triggers to your headaches?

_____Odors (Perfume, cigarettes) _ _Hunger (missing meals) _____Exercise
_ _Too much sleep (sleeping in) _ _Too little sleep (staying up late) _ _Fatigue
_ _Riding in a car _ _ Weather changes _ _Anxiety or stress _ _Menstrual cycles _ _Birth Control Pills
_ _Alcohol (wine, beer) _ _Certain foods (chocolate, cheeses, cold cuts, nuts)

17- Are there any warning signs BEFORE the headache begins?

_ _Visual changes: blurred vision, black spots, flashing lights, or double vision)
_____Tingling or numbness in the face, hands, arms or legs.

How long do these warning signs last?

18- How many hours do you sleep during a typical night?

19- How many times do you wake up at night?

20- Do you feel refreshed in the morning after a night's sleep?

21- How much coffee, tea or other caffeinated beverages (Pop, energy drinks) do you drink per day?

22- What medications or treatments have you tried for the headaches?
(include medications as well as massage, chiropractic treatments etc… and please specify of they were helpful or not)

Medication or Therapy	Effective	Ineffective

23- How often do you take medications for your headaches?
(specify the medication and the amount used per day or per week)

Medication name	Amount taken per day	Amount taken per week

24- What tests have you had for your headaches in the past?