

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 neadaches?

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.

