

Headache Questionnaire

Name: _____

Date: _____

Date of Birth: _____

Please answer the following questions to the best of your knowledge. This information will assist us in evaluating your child's headaches.

- 1) How long have the headaches been present? _____
- 2) How often do they occur? _____
- 3) Where are they located? _____
- 4) How long do they usually last? _____
- 5) Which family members, if any, have now or in the past had severe, recurrent headaches? _____

6) Check the correct response:	YES	NO
i) Child has missed school due to a headache	_____	_____
ii) School work has changed recently	_____	_____
lii) Child stops playing or goes to bed when has a headache	_____	_____
iv) Child has been "car sick"	_____	_____
v) Child has had a seizure or convulsion	_____	_____
vi) Child has behavior problems	_____	_____
vii) Child has learning problems	_____	_____
viii) Child has had a concussion or skull fracture	_____	_____
ix) A doctor has diagnosed "allergy" in child	_____	_____
x) Child has nor or has had bed-wetting problems	_____	_____
xi) Headaches awake child from sleep	_____	_____
xii) Headaches occur in the morning upon awakening	_____	_____
xiii) Headaches are common in the afternoon	_____	_____
xiv) Headaches are pounding or throbbing	_____	_____

7) Please check the column best describing the effect that food has on the child's headache:

Food	Increased	Decreased	No Change	Don't Know
Ice Cream				
Hot Dogs				
Cheese				
Coffee or Tea				
Milk				
Coke/Pepsi				
Chinese Food				
Chocolate				
Eggs				
Hot Soups				
Sugar				
Pizza				
Other				

Name: _____

8) How often are the following associated with the child's headache?

Symptom	All the time	Half of the time	Occasionally	Never
Nausea				
Bellyache or pain				
Vomiting				
Dizziness				
Passes out				
Slurred speech				
Blurred vision				
Spots/colors in front of eyes				
Numbness/tingling in arms/legs				
Weakness in arms/legs				

9) Please check column describing the effect of the following upon your child's headaches.

	Increase	Decrease	No Change	Don't Know
Riding in a car				
Exercise/Gym				
Reading				
Bright lights				
Watching TV				
Loud Sounds				
Aspirin				
Tylenol				
Sleep				
Vacations				
School days				
Quick movement of the head				
Menstrual periods				
Other				