Demographics and Headache Questionnaire

Name (full first, middle, and last name): _____

Date: _____ Handedness: _____ Ethnicity: _____

Date of Birth: _____ City of Birth: _____

Age: _____ Gender: _____

Do you have hearing loss or a hearing aid? YES / NO

Do you have visual problems that cannot be corrected with corrective lenses? YES / NO

Are you pregnant? YES / NO

Do you have epilepsy? YES / NO

Except for migraine, do you have a neurological disease or psychiatric problems (for example, traumatic brain injury, multiple sclerosis, autism, schizophrenia, bipolar disorder, depression, anxiety)?
YES / NO

If yes, what is your diagnosis?

_____

Do you have a history of alcohol abuse or drug dependency? YES / NO

Have you had a serious head or neck injury, including severe concussion (involving going to the hospital), or surgery?
YES / NO

If yes, when was your most recent concussion or neck injury?

_____

Please describe what happened and how you felt after the concussion or neck injury:

_____

_____

Do you take daily medications? YES / NO

If yes, what are the medications and what are they for?

_____

_____

Have you ever had a headache? (If no, you are done with the questionnaire) YES / NO

On a scale of 1-10, on average, how painful are your worst headaches (10 being most painful)? _____

If you had to describe the head pain, is it… (check all that apply)

- ☐ Throbbing
- ☐ Pulsating
- ☐ Pounding
- ☐ Burning / Pressing
- ☐ Steady
- ☐ Sharp
- ☐ Tight
- ☐ Dull
- ☐ Ache

Is the pain typically on one or both sides of the head? _____

If one side, which side? _____

During your worst headaches, do you have… (check all that apply)

- ☐ Nausea / Vomiting
- ☐ Teary eyes
- ☐ Eyelid drop
- ☐ Facial sweating
- ☐ Nasal congestion
- ☐ Facial or forehead flushing or sweating
- ☐ Sensation of fullness in ear
- ☐ Restlessness or agitation
- ☐ None of the above

During your worst headaches, are you very sensitive to… (check all that apply)

- ☐ Light
- ☐ Noise
- ☐ Strong smells
- ☐ Light touches on the face, arm, or leg
- ☐ None of the above

Do you notice any changes in your head pain in response to physical activity (e.g., walking up the stairs)? YES / NO

If yes, in response to physical activity, does your head pain get…

- ☐ Better
- ☐ Same
- ☐ Worse

How long do your worst headaches typically last? Please indicate if this is in minutes, hours, days, etc.

_____

Thinking back on the headaches you have just described, how many of these headaches have you had in your lifetime?

☐ 1-4 ☐ 5 or more

Before or during your worst headaches, do you notice any changes in your... (circle all that apply)

☐ Vision ☐ Difficulties with speech or balance

☐ Hearing ☐ None of the above

☐ Pins and needles

If yes, can you describe this sensation?

_____

_____

_____

_____

How many times has this happened?

☐ 1-2 times ☐ 3 or more times

How long does this sensation last?

_____

Does your headache always follow this sensation? YES / NO

Do you ever have similar sensations with no headache or with a different kind of headache? YES / NO

Thinking back to your worst headaches, that you just described, when was the last one?

_____

How many of your worst headaches do you have? (per week, month, year)

_____

Have you been diagnosed with migraine? YES / NO

How long have you had severe headaches? Please indicate if this is in days, months, or years.

_____

Have they changed in frequency? YES / NO

If yes, can you think of any reason why?

_____

_____

When do you typically get severe headaches? (check all that apply)

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ During sleep
- ☐ During the weekend
- ☐ Beginning of the week
- ☐ Middle of the week
- ☐ End of the week
- ☐ Caused by bright lights
- ☐ During or after sex
- ☐ During emotional stress
- ☐ After emotional stress
- ☐ During physical exertion
- ☐ After not eating for several hours
- ☐ After napping/ oversleeping
- ☐ After drinking alcohol
- ☐ Before menstrual cycle
- ☐ During menstrual cycle
- ☐ After menstrual cycle
- ☐ After bending head downward
- ☐ No pattern

What helps your severe headaches? (check all that apply)

- ☐ Sleeping
- ☐ Rest
- ☐ Eating
- ☐ Spinal adjustments
- ☐ Improving posture
- ☐ Dark quite room
- ☐ Medications
- ☐ Drinking coffee
- ☐ Muscle massage
- ☐ Cold packs
- ☐ Nothing

Thank you for your answers.