

Headache Assessment

Name _____ Occupation _____ Date _____

How many types of headaches do you have?

When did your headaches first start? _____

Are you aware of any event or circumstances that seemed to precipitate when your headaches first started?

How often do you get headaches? _____

Does anything trigger your headaches? _____

Do you have any warning that a headache is about to occur? (Describe)

Describe the pain as to:

PATTERN: Have you noted any time of the day, week, month, or year when your headaches appear?

LOCATION: Where is the pain?

PROGRESSION: Does the pain move from one area to another?

QUALITY: Describe the pain? (pressure, stabbing, sharp, etc.)

Which of the following precede or accompany your headaches (circle):

Light sensitivity

Noise sensitivity

Runny nose

Stuffy nose

Red eyes

Watery eyes

Itchy eyes

Unsteadiness

Nausea

Vomiting

Diarrhea

Constipation

Blind spots

Flashes of light

Blurred vision

Difficulty swallowing

Dizziness

Difficulty with speech

Numbness or tingling: where? _____

How many cups of coffee, tea, or cola do you drink per day? _____

If female, do your headaches have any relationship to your menstrual cycle or pregnancies? _____

How long do these headaches last if you take medications? _____

How long do these headaches last if you do NOT take medications? _____

How many hours of sleep do you normally get each night? _____

Do you sleep soundly? _____

Do you ever awaken with a headache? _____

Does a headache ever awaken you from a sound sleep? _____

Does a headache ever prevent you from falling asleep? _____

What medications have you taken in the past to prevent headaches? _____

What medications have you taken in the past to treat headaches once they occur? _____

What medications do you currently take? Dosage and how often.

What other methods do you use to prevent or relieve your headaches? _____

What other family members have headaches? _____

Have you seen other doctors for your headaches, list their name _____

What treatments were given to you? (Biofeedback, acupuncture etc.)

What tests have been done? (CAT scans, MRI, X-ray, etc.)

Do you have any allergies?

Have you ever had a seizure or convulsion?

How have your headaches affected your daily activities and lifestyle?

What do you think causes your headaches?
