Headache Questionnaire

Name of patient _____ Date _____

Date of Birth _____

Person completing questionnaire _____ Relationship _____

1. How long have you been having headaches? _____

2. Is the headache

in the forehead?	Yes	No
in the temple?	Yes	No
in the back of the head?	Yes	No
all over?	Yes	No
on one particular side?	Yes	No

3. Do you know before you get the headache that it is coming? Yes No
   If so, how can you tell? _____

4. When you have a headache do you have:

Nausea	Yes	No
Vomiting	Yes	No
Problems seeing	Yes	No
Bloating	Yes	No
Light headedness	Yes	No
Abdominal Pain	Yes	No
Dizziness	Yes	No
Itching	Yes	No
More energy	Yes	No
Less energy	Yes	No

5. How many times a week do you have a headache? _____

6. When was the last time you had a headache? _____

7. How many times did you have a headache in the past 4 weeks? _____

8. What helps you feel better? _____

9. Has anyone else in your family had this kind of headache? _____

10. Do you have allergies? Yes No
    If so, what kind? _____

11. Do you know of anything which definitely brings on the headache? _____

Developmental-Behavioral Pediatrics
Partners-in-Healing • 10505 Wayzata Blvd #200 • Minnetonka, MN 55305 • 763-546-5797

Developmental-Behavioral Pediatrics
Partners-in-Healing • 10505 Wayzata Blvd #200 • Minnetonka, MN 55305 • 763-546-5797