Spine & Sport Biomechanical Rehabilitation Center Headache Questionnaire

Patient Name: _____ **DOB:** _____ **Date:** _____

Please answer the following questions to the best of your ability regarding your headaches:

When did your headaches start? _____ days ago _____ weeks ago _____ months ago _____ years ago

Did your headache start after an injury? □Yes □ No If yes, describe: _____

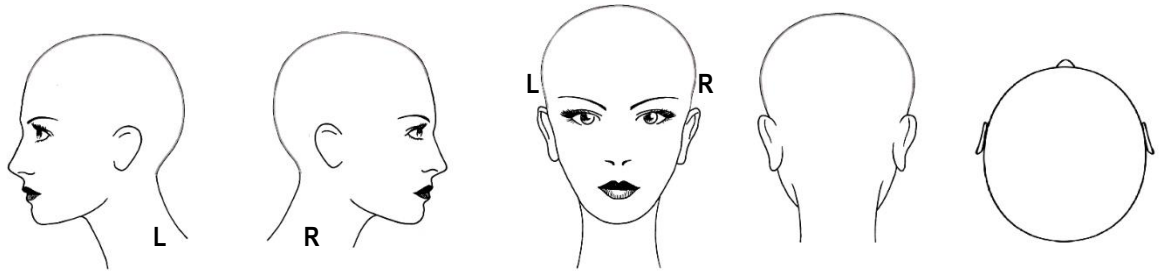
Did your headache start after an illness? □Yes □ No If yes, describe: _____

Did your headache begin when you started/changed medication? □Yes □ No If yes, what medication? _____

How many days in a month do you have a headache? _____

How severe are your headaches? (0 to 10 = worst pain possible): **Range:** 1 2 3 4 5 6 7 8 9 10 **Average Pain:** _____ / 10

Please indicate on the diagram below where you experience your headaches:



Your headaches usually feel: (check all that apply)

□ Throbbing □ Pulsing □ Dull □ Tight □ Shooting □ Other: _____
□ Achy □ Stabbing □ Burning □ Pressure □ Other: _____ □ Other: _____

How long do your headaches last in HOURS? _____ □ All Day

Your headaches are worse in the: □ morning □ afternoon □ evening □ during the night □ no pattern Other: _____

Are your headaches worse: □Lying down □ Standing □ Sitting □ At rest □ With activity Explain: _____

Please check the symptoms you experience <u>during</u> your headache? (mark all that apply)

□ Nausea or upset stomach/vomiting
□ Sensitivity to light (prefer a dark room)
□ Sensitivity to sound (prefer a quiet room)
□ Sore/stiff neck
□ Vision changes (blurred, spots, patterns)
□ Eye tearing
□ Runny nose
□ Diarrhea / Constipation
□ Stroke like symptoms (facial droop, droopy eye lid, unable to move arm or leg)
□ Sensitivity to smells
□ Ringing in ears
□ Increased appetite
□ Decreased appetite
□ Anxiety
□ Irritability
□ Memory problems
□ Dizziness/vertigo
□ Confusion
□ Difficulty thinking/concentrating/focus
□ Difficulty speaking/slurred speech
□ Increased Urination
□ Eye-redness (Right / Left / Both)
□ Drooping eyelid (Right / Left / Both)
□ Swelling of eyelid (Right / Left / Both)
□ Sleepiness
□ Numbness/Tingling Where? _____

Please check any triggers, things that bring on a headache

Physical exertion: □ Coughing □ Talking □ Chewing □ Exercise Environmental: □ Allergies □ Weather changes
Hormonal: □ Menses □ Menopause □ Stress
Sleep: □ Lack of sleep □ Too much sleep □ Other: _____

Relieving Factors

□ Lying down □ Dark room □ Hot compress □ Medication _____
□ Standing □ Massage □ Cold compress □ Other: _____

Anything else you feel we should know about your headaches? _____

_____

_____