Headache Questionnaire

Name: _____

1. When did your headaches start? (months/years?) _____

2. Did your headaches start after a head injury? ☐ **Yes** ☐ **No**

3. Did your headache start after an infection? ☐ **Yes** ☐ **No**

4. Did your headache begin when you started or changed a medication? ☐ **Yes** ☐ **No**
If yes, which medication? _____

5. How many days in a month do you have a headache? _____
How many headache-free days do you have in a month? _____

6. How severe are your headaches? (from 0-10, 10=most severe pain) Average ___ Most severe ___

7. Do you have more than one type of headache? ☐ **Yes** ☐ **No**
If yes, focus the following questions on your worst/most disabling headache type.

8. Where are your headaches located in general? Check all that apply.

☐ Temple ☐ R ☐ L ☐ Front of head ☐ Around head
☐ Back of head ☐ R ☐ L ☐ Neck ☐ Jaw
☐ Top of head ☐ R ☐ L ☐ Eye ☐ R ☐ L ☐ Ear ☐ R ☐ L
☐ Other _____

9. What do your headaches feel like? Check all that apply.

☐ Throbbing/pulsing ☐ Dull ☐ Shooting
☐ Achy ☐ Stabbing ☐ Burning
☐ Tight ☐ Pressure ☐ Other _____

10. How long do your headaches last in HOURS? Shortest ___ Longest ___ Average ____
Or are they constant? ☐ **Yes** ☐ **No**

11. What time of day are your headaches worse? ☐ Morning ☐ Afternoon ☐ Evening

12. Are you headaches worse lying down or standing? _____

13. Do your headaches wake you up in the middle of the night? ☐ **Yes** ☐ **No**☐
If yes, how often? _____

14. Premonitory symptoms: Check off any of these symptoms you experience *1-2 days before onset of headache.*

☐ Hyperactive ☐ Difficulty with speech ☐ Food cravings
☐ Depressed feeling ☐ Sensitive to light ☐ Increased appetite
☐ Irritability ☐ Sensitive to sound/noise ☐ Decreased appetite
☐ Feeling sluggish ☐ Dizziness ☐ Increased urination
☐ Difficulty concentrating ☐ Excessive yawning ☐ Stiff neck

15. Symptoms during your headache: Check all that apply.

☐ Nausea/vomiting ☐ Change in pupil size ☐ Memory problems
☐ Sensitivity to light (prefer dark) ☐ Dizziness/vertigo ☐ Increased appetite
☐ Sensitivity to sound (prefer quiet) ☐ Imbalance ☐ Decreased appetite
☐ Sore/stiff neck ☐ Confusion ☐ Numbness/tingling
☐ Vision changes (blurred, spots, patterns) ☐ troke-like symptoms ☐ Insomnia
☐ Eye tearing in only ONE EYE ☐ Sensitivity to smells ☐ Sleepiness
☐ Runny nose in only ONE NOSTRIL ☐ Difficulty concentrating ☐ Diarrhea
☐ Ringing in ears ☐ Slurred/Difficulty with speech ☐ Constipation
☐ Eye redness ☐ Increased urination ☐ Other _____
☐ Drooping eyelid ☐ Anxiety
☐ Swelling of eyelid ☐ Irritability

16. Aura: Check off any symptoms that you have BEFORE the headache begins.

Visual

☐ Flashing lights ☐ Loss of vision in one eye ☐ Double vision
☐ Zizag lines ☐ Loss of vision on one side ☐ Distorted vision
☐ Wavy lines ☐ Total blindness ☐ Spots: bright/dark
☐ Geometric forms ☐ Tunnel vision ☐ Other _____

Sensory and other

☐ Numbness/tingling ☐ Dizziness/unsteadiness ☐ Confusion/déjà vu/hallucinations
☐ Speech difficulty ☐ Lightheadedness ☐ Other _____
☐ Vertigo ☐ One-sided weakness

If you have any of these symptoms, they usually last ___ minutes and stop ___ minutes before pain starts,
OR occur ☐ during the head pain ☐ after the head pain ☐ without the head pain

17. Provoking factors: Check off any triggers/things that bring on a headache.

Food/beverage:
☐ Fasting/skipping meals
☐ Chocolate
☐ Caffeine
☐ Nitrates
☐ MSG
☐ Aged Cheese

Alcoholic beverages:
☐ White wine
☐ Red wine
☐ Other _____

Physical exertion:
☐ Coughing
☐ Talking
☐ Chewing
☐ Exercise
☐ Sexual intercourse

Environmental:
☐ Allergies
☐ Weather changes
☐ Altitude
☐ Sunlight

Hormonal:
☐ Before menses
☐ During menses
☐ After menses
☐ Pregnancy
☐ Menopause

Sleep:
☐ Lack of sleep
☐ Too much sleep
☐ Change in wake/sleep

Stress;
☐ Work
☐ Home
☐ Family
☐ Spouse

Other:
☐ _____

18. Activity that worsens headache:

☐ None ☐ Walking ☐ Climbing steps ☐ Exercise ☐ Other

19. Relieving factors:

☐ Lying down ☐ Ice/cold compress ☐ Massage
☐ Standing ☐ Hot compress ☐ Pregnancy
☐ Dark quiet room ☐ Keeping active/pacing ☐ Other _____

20. Have you had to go to the hospital or emergency room for headaches? ☐ Yes ☐ No☐

21. Procedures previously tried for headaches: Check all that apply.

☐ Occipital nerve block ☐ Botox
☐ Supraorbital nerve block ☐ Head/neck injections under X-ray/ultrasound guidance
☐ Other _____

22. Alternative treatments used: Check all that apply.

☐ Magnesium ☐ Melatonin ☐ Physiotherapy
☐ Riboflavin (vitamin B2) ☐ Iron ☐ Massage therapy
☐ Coenzyme Q10 ☐ Feverfew ☐ Chiropractic care
☐ Butterbur (petasides) ☐ Acupuncture ☐ Other _____

23. Which acute medications have you tried? (Medications to stop or abort a headache)

	On average, how many days per week?	Does it help? Yes/No	Currently taking?
Acetaminophen (Tylenol)			
Ibuprofen (Advil/Motrin)			
Naproxen (Aleve)			
Aspirin			
Diclofenac (Cambia)			
Indomethacin (Indocin)			
Ketorolac (Toradol)			
Celecoxib (Celebrex)			
Baclofen			
Cyclobenzaprine (Flexeril)			
Tizanidine (Zanaflex)			
Diphenhydramine (Benadryl)			
Other antihistamines			
Excedrin			
Midrin (Duradrin, Epidrin)			
Fioricet, Fiorinal			
Dihydroergotamine (Migranal, DHE)			
Lidocaine nasal spray			
Metaxalone (Skelaxin)			
Metoclopramide (Maxeran, Reglan)			
Ondansetron (Zofran)			
Prochlorperazine (Stemetil)			
Tramadol			
Opioids (codeine, morphine, Dilaudid, etc.)			
Eletriptan (Relpax)			
Rizatriptan (Maxalt)			
Zolmitriptan (Zomig)			
Frovatriptan (Frova)			
Sumatriptan (Imitrex)			
Almotriptan (Axert)			
Naratriptan (Amerge)			
Ubrogepant (Ubrelvy)			
Other			

24. What preventive medications have you tried? (Medications taken daily to prevent headaches)

	Dose/day	How long did you take it? Weeks/months/years	If stopped, why? No benefit/side effects/other
Amitriptyline (Elavil)			
Nortriptyline (Aventyl)			
Candesartan (Atacand)			
Lisinopril (Zestril)			
Propranolol (Inderal)			
Metoprolol (Lopressor)			
Topiramate (Topamax)			
Verapamil (Calan)			
Venlafaxine (Effexor)			
Duloxetine (Cymbalta)			
Gabapentin (Neurontin)			
Pregabalin (Lyrica)			
Divalproex (Valproic acid)			
Pizotifen (Sandomigran)			
Flunarazine (Sibelium)			
Atogepant (Qulipta)			
Erenumab (Aimovig)			
Fremanezumab (Ajovy)			
Galcanezumab (Emgality)			

Headache Impact Test - 6

	Never	Rarely	Sometimes	Very Often	Always
1 When you have headaches, how often is the pain severe?					
2 How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?					
3 When you have a headache, how often do you wish you could lie down?					
4 In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?					
5 In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?					
6 In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?					
	COLUMN 1 (6 points each)	+ COLUMN 2 (8 points each)	+ COLUMN 3 (10 points each)	+ COLUMN 4 (11 points each)	+ COLUMN 5 (13 points each)

To score, add points for answers in each column.
Please share your HIT-6 results with your doctor.

Total Score

Higher scores indicate greater impact on your life.

Score range is 36–78.

HIT-6™ US (English) Version 1.1
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<49 little to no impact; 50-55 some impact; 56-59 substantial/severe pain; >60 very severe impact/disabling

Allodynia Questionnaire (ASC-12)

How often do you experience increased pain or unpleasant sensation on your skin during your most sever type of headache when doing the following?	Does not apply to me	Never	Rarely	Less than half the time	Half of the time or more
	Score 0	Score 0	Score 0	Score 1	Score 2
Combing your hair					
Pulling your hair back (e.g. ponytail)					
Shaving your face					
Wearing eyeglasses					
Wearing contact lenses					
Wearing earrings					
Wearing a necklace					
Wearing tight clothing					
Taking a shower (when the water hits your face)					
Resting your face or head on a pillow					
Exposure to heat (e.g. cooking, washing face with hot water)					
Exposure to cold (e.g. using an ice pack, washing face with cold water)					
Total Score					
Sum of total scores					

0-2 none, 3-5 mild, 6-8 moderate, 9+ severe allodynia