

Headache Questionnaire

Name: _____

Date: _____

Check the statements that apply to you:

- 1. I have a headache right now.
- 2. I have taken medication within the last four hours. (Names) _____
- 3. I have seen other medical professionals to help me with my headaches.

A. Name _____ Date _____ Diagnosis _____

B. Name _____ Date _____ Diagnosis _____

4. I get headaches:

- Every day
- Once a week
- Several times a week
- Rarely
- Other _____

5. My headache is accompanied by:

- Blurred vision and pain behind my eyes.
- A fever.
- A stiff neck and sensitivity to light.
- Persistent throbbing in my head.
- Mental confusion.
- Severe pain that radiates to my neck area.

6. I can also say that:

- I have recently experienced a blow to the head, a fall, or an accident.
- My pain starts when I turn my head quickly to the side.
- My pain gets worse when lying down and improves by being upright.
- I get strong headaches that awaken me in the night.
- I get headaches that wake me in the night.
- I get headaches following activities in which I strain or exert myself.
- This is the worst pain I have had in my life.

7. Describe your head pain in your own words.

8. List any factors that you think have contributed to your having a headache:

9. List all the remedies you are taking currently for headaches, both prescription and other:

10. Color in the areas where you feel your pain on these diagrams:



Your Signature _____ Date _____



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