Headache History Questionnaire

1. On a scale of 1-10, with "10" being the worst pain imaginable above the shoulders, how many mornings per week do you wake with a "0" (zero)? ___
2. On a scale of 1-10, what's the average "number" you usually wake with? ___
3. What **%** of your ***waking*** time do you have some degree of headache? ___
4. What **%** of your ***waking*** time do you have a "0" (zero) without taking medications? ___
5. What is your average headache pain level (1-10 scale) throughout the day? ___
6. On a scale of 1-10, what is the worst pain level you experience? ___
7. What time of day do you usually experience your worst headaches? ___
8. How many times per week (or month) might you experience your worst pain? ___
9. Where does your pain seem to originate from?

_____

10. How would you describe your pain? (examples: throbbing, squeezing, pressure, dull, stabbing, shooting, etc.)

_____

11. Please circle the types of health care providers you've seen for your headaches.
    MD Neurologist ENT Internist Physical Therapist Chiropractor Dentist
    Others: _____
12. What medical tests have been performed regarding your headaches?
    CT scan MRI Xray Blood analysis Other: _____
13. What types of procedures or treatments (including dental) have you had regarding your headaches?

_____

14. What medication(s) do you now take to prevent your headaches?

_____

15. What medications have you tried to prevent your headaches?

_____

16. What prescription or over-the-counter medications do you take to relieve you headaches? (and how much)

_____

Shade in the areas below where you experience your discomfort