

## 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.  
Neurologist   ENT   Internist   Dentist   Oral Surgeon   Physical Therapist   Chiropractor  
Others: \_\_\_\_\_
12. What medical tests have been performed regarding your headaches?  
CT scan   MRI   X-ray   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)  
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