



# Headache Questionnaire



Please return to school nurse

Student Name \_\_\_\_\_

Grade \_\_\_\_\_

Date \_\_\_\_\_

What year did your current headaches begin? \_\_\_\_\_ When was your last headache? \_\_\_\_\_

How many headaches do you have each month? \_\_\_\_\_ How long do they last? \_\_\_\_\_

How would you describe the pain of your most serious headaches (check all that apply):

- |                                    |  |  |
|------------------------------------|--|--|
| <input type="checkbox"/> throbbing | <input type="checkbox"/> pressure-like | <input type="checkbox"/> stabbing      |
| <input type="checkbox"/> pulsating | <input type="checkbox"/> aching        | <input type="checkbox"/> electric-like |
| <input type="checkbox"/> dull      | <input type="checkbox"/> sharp         | <input type="checkbox"/> vise-like     |

Are your headaches **brought on** by (check all that apply):

- |                                   |   |   |  |
|-----------------------------------|---|---|--|
| <input type="checkbox"/> smoke    | <input type="checkbox"/> hunger         | <input type="checkbox"/> bright light   | <input type="checkbox"/> change in weather       |
| <input type="checkbox"/> noise    | <input type="checkbox"/> glare          | <input type="checkbox"/> lack of sleep  | <input type="checkbox"/> relaxation after stress |
| <input type="checkbox"/> exercise | <input type="checkbox"/> odors          | <input type="checkbox"/> too much sleep | <input type="checkbox"/> your periods            |
| <input type="checkbox"/> stress   | <input type="checkbox"/> food additives | <input type="checkbox"/> certain foods  | <input type="checkbox"/> hormonal changes        |

Do your headaches occur on any particular day of the week or time of day? \_\_\_\_\_

Do you have any warning signs before the start of a headache? \_\_\_\_\_  
Yes No

Describe: \_\_\_\_\_

Check any of the following **symptoms** you have with your headaches:

- |                                    |                                   |  |                                    |
|------------------------------------|-----------------------------------|--|------------------------------------|
| <input type="checkbox"/> nausea    | <input type="checkbox"/> numbness | <input type="checkbox"/> neck pain         | <input type="checkbox"/> confusion |
| <input type="checkbox"/> vomiting  | <input type="checkbox"/> weakness | <input type="checkbox"/> light sensitivity |                                    |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> fever    | <input type="checkbox"/> noise sensitivity |                                    |

Have you ever been treated for headaches? \_\_\_\_\_  
Yes No

If yes, with what are you currently being treated? \_\_\_\_\_

Parent Signature: \_\_\_\_\_

