Jefferson Pediatrics

Pt. Name:____________________ Completed By:______________________

Date:______________________

Age:________________________

Headache Questionnaire:

1. When did the headaches begin ____
2. Average duration of the headache? ______________ Mins/hours
3. How long do they last and how often?________________________________
4. Severity of the headache on a scale of 1- 10 __________________________
5. When do they usually come on, what brings it on?____
6. What does the headache keeps you from doing?____
7. What helps relieve HA? ______ (Ibuprofen/Tylenol/eating/lying down in dark room/vomiting)
8. Nightly sleep __________ hrs from ______pm to _____am
9. Can you fall asleep easily and sleep well?____
10. Do you feel rested/energized or tired/sleepy when you wake up?
11. HA affects your moods and energy?____
12. Do you take naps during the day yes/no, feel tired and sleepy yes/no
13. Affects on your personal/family/school/homework?____________________________________
14. Do you lose concentration and can't focus in class or during homework? __________________
15. Is it affecting school grades/sports/career?____
16. How do you feel overall?____
17. Any other concerns you want to discuss?____