Name:
MR #:
DOB:

HEADACHE QUESTIONNAIRE
INITIAL CONSULATION

Patient's Name: _____ Sex: M or F Age: _____
Date of Birth: ___/___/___ Today's Date: ___/___/___
Person filling out form: _____ Relationship to patient: _____
Patient's primary doctor: _____
Referring doctor: _____

Please answer the following questions to the best of your ability. Please cross out/check response if available. This information will be used to assist in your child's care and may be used for study purposes. If there is more than one type of headache (i.e., a frequent mild headache and a rarer severe headache), please describe the information for both. If multiple choices are available, please cross out/check all that apply.

PLEASE DESCRIBE THE HEADACHES:

ONSET

1. When did your/ your child's headache begin? _____

Headaches became a problem _____ Months □ Years □ ago.

2. Does your/your child have more than one type of headache?

_____

3. Precipitating Event - *Was there a precipitating event or trigger for the current headache problem?*

	None known		Illness: _____
	Speciffic stress: _____		Menarche (first menstrual period)
	Injury: _____		Birth control pill
	Motor vehicle accident		Others: _____

HEADACHE CHARACTERISTICS:

4. Frequency of Headaches: ***On average, how often does the headache occur?***

	_____ times in a day		_____ days in a year
	_____ days a week		_____ daily for _____ hours/day
	_____ days in a month		Daily and constant (24/7)

Are they increasing in frequency? □ Yes □ No

They are more frequent on:

	No pattern		Summer
	Weekdays		Spring
	Weekends		Fall
	Vacation		Winter

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5. Onset of each headache:

Headaches typically begin: □ Gradually □ Suddenly □ Varies

How long before they reach maximal intensity? _____ □ Minutes □ Hours

Does the headache occur at a particular time of day? □ Yes □ No

	Waking up		While asleep
	Morning		Evening
	Afternoon		Others:

6. Duration of the headaches:

Headaches usually last (with medication) _____ □ Minutes □ Hours □ Days

Headaches usually last (without medication) _____ □ Minutes □ Hours □ Days

How many hours does the headache last?

Shortest: _____ Longest: _____ Average: _____

7. Intensity of the headache: On average, how bad are the headaches (Please choose ONE)?

Mild (GREEN) Moderate (YELLOW) Severe (RED)

What is the severity on a scale of 0 to 10 (10 = worst)?

Mildest: _____ Worst: _____ Average: _____

Headache level today: _____

Does the headache change your or your child's activity level (i.e., stop playing)?

□ Yes □ No

Does activity or playing make the headache worse?

□ Yes □ No

8. Location of Headaches - *Where do you/your child feel the pain during your headaches*?

	Both sides		May be either side		Right side only		Left side only
	Forehead		Behind/around eye/s		Back of head		Top of head
	All over		Back of neck		Others:		

9. Pain Type: What does the headache pain feel like?

	Constant		Pressue/squeezing		Stabbing/sharp		Dull
	Tight band		Throbbing/pounding		Back of head		Top of head
	"There"		I can't describe it		Others:		

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10. Headache Triggers: Do any of the following bring on/ trigger your /your child's headaches?

	Less sleep		Stress		Weather		Loud noise
	Too much sleep		During stress		Exercise		Bright lights
	Coughing/sneezing		After stress (after test, weekend)		Menses		Smells/odor
	Concentrating		Screen/Computer work		Food: _____		Caffeine
	Other triggers:						

11. Premonitory symptoms:
Do you or does your child act different BEFORE the headache starts?
☐ Yes ☐ No

	Tired/fatigue		Irritable		Neck pain		Yawning
	Flushed face		Mood changes		Sunken eyes		Diarrhea
	Food cravings		Personality change		Foggy/slow		Constipation
	Other symptoms:						

12. Aura Symptoms: *Do you or does your child ever experience any of these warning symptoms before the headache begins?*
☐ Yes ☐ No

	Bright lights		Partial loss of vision		Spinning sensation		Slurred speech
	Colored lights		Blindness/black out		Feeling off balance		Word finding problem
	Zigzag lines		Numbness/tingling on one side of face/arm/leg		Weakness on one side of face/arm,/eg		No, I don't have any symptoms
	Other symptoms:						

When do the aura symptoms occur?
☐ Before headache ☐ During headache ☐ After headache

How long do the aura symptoms occur?
☐ _____ seconds ☐ _____ minutes ☐ _____ hours ☐ _____ days

13. Associated Symptoms: *Do you or your child experience any of these symptoms during headaches?*
☐ Yes ☐ No

	Bright lights bother you		Spinning sensation/ vertigo		Changes in vision: _____		Tearing of eyes
	Loud sounds bother you		Feeling off balance/ light headed		Ringing ears (which side)		Runny/stuffy nose
	Nausea/upset stomach		Decrease appetite		Sensitive scalp/hair/eyes		Flushed face
	Vomiting		Diarrhea		Confusion/foggy		Droopy eye
	Smells/odor bother you		Constipation		Mood changes/ irritability		Frequent urination
	Other symptoms:						

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14. Alleviating F actors - ***During a headache, what makes you or your child feel the most comfortable?***

	Lying down		Resting in a dark room		Hot pack on head		Massage
	Sleeping		Resting in a quiet room		Cold pack on head		Acupuncture
	Keeping physically active		Pacing back and forth		Applying pressure		Exercise
	Others:						

15. Aggravating Factors - ***During a headache, what makes your headache worse?***

	Lying down		Movement/physical activity		Bright lights		Coughing/sneezing
	Screen		Exertion/exercise		Loud sounds/noise		Bending forward
	School work		Sitting/Standing		Smells/odor		
	Others:						

HEADACHE-RELATED INVESTIGATIONS

16. Doctor Visits for Headache: ***How many times would you estimate that you or your child visited the following because of headaches in the past 1 year?***

- ☐ Family physician _____
- ☐ Walk-in clinic _____
- ☐ Emergency department _____

17. Previous Testing: ***Have you had any of the following tests done to investigate your headaches? If yes, please indicate the approximate date and results:***

- ☐ CAT Scan: _____
- ☐ MRI: _____
- ☐ EEG: _____
- ☐ Sinus X-rays: _____
- ☐ Neck X-rays: _____
- ☐ Other: _____

18. Previous Consultations - ***Have you seen any of the following about your/your child's headaches? If yes, please give the name, and approximate date:***

- ☐ Neurologist
- ☐ Pain clinic
- ☐ Allergy specialist
- ☐ Psychologist
- ☐ Others _____
- ☐ Pediatrician
- ☐ Ear, nose and throat specialist
- ☐ Eye doctors
- ☐ Psychiatrist

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HEADACHE QUESTIONNAIRE
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HEADACHE-SPECIFIC TREATMENT

19. Multi-Disciplinary Health Care - ***Have you or your child seen any of the following about headaches?***

- ☐ Chiropractor
- ☐ Acupuncturist
- ☐ Nutritionist
- ☐ Massage Therapist Others _____
- ☐ Naturopath/hoemopath
- ☐ Physiotherapist

20. Headache-Related Purchases - ***Have you purchased any of the following to try to treat your/your child's headaches?***

- ☐Hot/cold packs
- ☐Naturopathic meds
- ☐Eye mask
- ☐Mouth-guard
- ☐Others _____
- ☐ Aromatherapy
- ☐ Herbs/Herbal supplements
- ☐ Anti-inflammatory rubs
- ☐ Headache self-help books

21. Previously Tried Headache Medications - ***Please include all Over-The-Counter and Prescription Medications PREVIOUSLY used to TREAT your/your child's headaches but have stopped using*:**

Medication Name	Approximate start and end date	Dose	Response to treatment	Reasons for stopping medication/Side effects

Name:
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DOB:

HEADACHE QUESTIONNAIRE
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22. Current Headache Medications - ***Please include all Over-The-Counter, Herbal products and Prescription Medications/Pain***

*Relievers that you/ your child **CURRENTLY** use to **TREAT** headaches:*

Medication Name	Approximates Date Started	Dose	Maximum dose/day	Max # days/month	Response	Side effects

23. Headache Relief from Medications - ***How long does it take before you become pain-free after taking your current headache medications?***

☐Within 1 hour ☐ 1- 2 hours
☐➢ 2hours ☐ I never become pain-free after medication

BIRTH and PAST HISTORY

Mother's PREGNANCY:

Any problems? ☐ Yes ☐ No

Mother's previous pregnancies/miscarriages_____ Other children_____

DELIVERY:

Any problems? ☐ Yes ☐ No
☐ Full term ☐ Preterm (early)
☐ Breech ☐ Forceps ☐ C-section

NEWBORN:

Any problems? ☐ Yes ☐ No

Birth weight:

How long in hospital?_____ Intensive care: ☐ Yes ☐No

Up to date on Immunizations? ☐ Yes ☐ No
Any other hospitalization? ☐ Yes ☐ No
Any surgeries? ☐ Yes ☐ No
Any recent travel outside the country? ☐ Yes ☐ No
Any exposure to toxic substances? ☐ Yes ☐ No
Any medication allergies? ☐ Yes ☐ No

If yes: please list all medications: _____

Name:
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HEADACHE QUESTIONNAIRE
INITIAL CONSULATION

Do you or does your child have any history of:

	Head trauma		Stroke		Heart disease		Depression
	Seizures		Kidney disease/stones		Abnormal heart rhythm		Anxiety
	Infection of brain		Asthma		ADD/ADHD		Behaviour issues
	Others:						

Do you or does your child have any sleep issues:

	Snoring		Night terrors/ nightmares		Bedwetting		Insomnia
	Restless sleep		Excessive daytime sleepiness		Abnormal movement during sleep		Sleeplessness
	Others:						

Any sleep test done in the past?

☐ Yes ☐ No

Does your child have any history of:

	Abdominal migraine		Cyclic vomiting syndrome		Benign paroxysmal vertigo		Benign paroxysmal torticollis
	Infant colic		Alternating hemiplegia		Vestibular migraine		Motion sickness
	Sleep walking		Sleep talking				
	Others:						

Life style-related questions:

Sleep: How many hours of sleep do you or does your child get each night? _____

Bedtime _____ Wake up time _____on weekdays _____ on weekends

Do you or does she/he have any problem falling asleep? ☐Yes ☐No

Do you or does she/he have any problem staying asleep? ☐Yes ☐No

Do you or does she/he ever wake up in the morning with a headache? ☐Yes ☐No

Do you or does she/he get more headaches on a certain day of the week? ☐Yes ☐No

Which days? Mon Tues Wed Thurs Fri Sat Sun

Exercise:

How many times a week do you or does your child do physical exercise? _____

Describe what kind of exercise: _____

Drinking:

____# of 8 oz glasses OR ____Total ml/L/day

On average, how much caffeinated drinks do you or does she/she consume daily?

(*please note the number of drinks/per day*)

Coffee _____

Tea _____

Soft drinks/cola/pop (eg Coke) _____

Eating:

Do you or does your child skip meals? ☐ Yes ☐ No

Which meals? ☐ Breakfast ☐Lunch ☐ Dinner

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Any history of the following?
☐ Smoking ☐ Alcohol ☐ Illicit drug use

For GIRLS only:
What age was the first period? _____ Are they regular? ☐ Yes ☐ No
Are your headaches WORSE with your periods? ☐ Yes ☐ No ☐ Not sure

EARLY DEVELOPMENT:
Any concerns with early development? ☐ Yes ☐ No
If yes, please give details:

CURRENT SCHOOL:
Name of School: _____ Grade: _____
School type: ☐ Regular ☐ Special
☐ Public ☐ Private
☐ Home schooled ☐ College
Any concerns with current school functioning? ☐ Yes ☐ No
Any therapies (PT, ST, OT, tutoring)? _____
Performance in school (recent grades)? _____
Any social issues (i.e., bullying, etc), learning problems in school? ☐ Yes ☐ No

SOCIAL HISTORY:
Who lives currently in the home with the child?
Any concerns at home? ☐ Yes ☐ No
Please note current status of biological parents:
☐ Married/living together ☐ Divorced/Separated
Does your family have a drug plan/coverage?
☐ Yes ☐ No

FAMILY HISTORY
Mother's name _____ Age: _____ Health: _____
Occupation: _____
Father's name _____ Age: _____ Health: _____
Occupation: _____
Brother(s) name _____ Age: _____ Health: _____
Sister(s)name _____ Age: _____ Health: _____

Is there a family history of any of the following?:

	Early stroke (<45 yo)		Seizure/epilepsy		Depression		Heart disease
	Brain aneurysm		Learning problems		Anxiety		Clotting problems
	Brain tumor		Hypermobile joints		Other mental health issues:_____		Miscarriages (repeated)
	Others:						

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Is there a family history of any of the following headache disorders?

	Age	Headaches (Any type)	Migraine	Tension Headache	Sinus Headache	Other medical/ mental health concerns
Father						
Mother						
Siblings						
Brothers						
Sisters						
Dad's Father						
Dad's Mother						
Mom's Father						
Mom's Mother						
Aunts/Uncles	**Number**					
Dad's Brothers						
Dad's Sisters						
Mom's Brothers						
Mom's Sisters						
OTHERS____						

PATIENT OPINIONS/QUESTIONS:
What specific questions do you want us to answer in this clinic visit?
1. _____
2. _____
3. _____

Do you or your child agree in including the information given in this questionnaire in the Canadian Pediatric Headache Registry?

☐ Yes, I agree ☐ No, I don't want to participate in the registry

_____ Date: _____
Name and signature of patient

_____ Date: _____
Name and signature of parent/guardian

Name:
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PEDIATRIC HEADACHE DISABILITY QUESTIONNAIRE

HEADACHE-RELATED DISABILITY

The following questions try to assess how much the headaches are affecting your day-to-day activity. Your answers should be based on the **last three (3) months (90 days)**. There are no "right" or "wrong" answers so please put down your best guess.

1. How many full school days of school were missed in the last 3 months due to headaches? If you do not attend school enter zero in the box.	
2. How many partial days of school were missed in the last 3 months due to headaches (do not include full days counted in question #1, if you do not attend school enter zero in the box)?	
3. How many days in the last 3 months did you function at less than half of your ability in school because of a headache (do not include days counted in questions # 1 and 2)?	
4. How many days were you not able to do things at home (i.e., chores, homework, etc.) due to a headache?	
5. How many days did you not participate in other activities due to headaches (i.e., play, go out, sports, etc.)?	
6. How many days did you participate in these activities, but functioned at less than half your ability (do not include days counted in question #5)?	
Total PedMIDAS Score	
PedMIDAS Grading Scale	

PedMIDAS Total Score	DISABILITY GRADE
0-10	Little or none
11-30	Mild
31-50	Moderate
>50	Severe

On how many days in the last 3 months did you have a headache? (If a headache lasted more than one day, count each day)	
On average, how painful were these headaches **RED** (STOPS you) **YELLOW** (SLOWS you down) **GREEN** (you can GO)	
How many visits to the Emergency Room have you or your child had in the last 3 months for headache treatment? (If you did not have any enter zero in the box)	

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PEDIATRIC HEADACHE DISABILITY QUESTIONNAIRE

Please respond to each question or statement by marking one box per row.

In the past 7 days.....	Never **1**	Almost never **2**	Sometimes 3	Often 4	Almost always 5
I felt afraid to go our alone					
Being worried made it hard for me to be with my friends					
It was hard to do school work because I was nervous or worries					
I felt afraid					
I worried when I was at home					
I felt worried					
I worry that my health might get worse					
I worry about doing well in school					
TOTAL					
SCORE					

In the past 7 days.....	Never 1	Almost never 2	Sometimes 3	Often 4	Almost always 5
I felt too sad to do things with friends					
I felt sad					
I felt lonely					
I was less interested in doing things I usually enjoy					
I was hard for mt care about anything					
It was hard for me to have fun					
I felt like I couldn't do anything right					
I felt everything in my life went wrong					
TOTAL					
SCORE					