Hunterdon Pediatric Associates
Parent / patient check-list for
Headache Evaluation

Patient's name_____ Date of birth_____ Today's Date_____

We would like to gather some information from you about your headaches. Please complete both sides of the paper by circling yes or no, and filling in the blanks. Give the paper to the doctor or nurse practitioner in the examination room for review.

When did the headaches begin? (How long have you had it?)_____

How intense is the headache on a scale of one to ten? ____/10

How often do you have the headache? **(Circle one)**

More than once a day
Once a day
A few times a week
Once a week
Less than once a week

Do you have the headache on weekdays, weekends or both? **(Circle one)**

Is the pain continuous all the time, or does it come and go? **(Circle one)**
What part of the day does the headache usually start? _____

What does the pain feel like? (sharp, pounding, squeezing, etc)_____
Where do you feel the pain in your head? _____
Is the pain mostly on one side? Yes/No If yes, which side?
What makes it better? _____
Do you use medicine for the headache? (please give details)
What makes it worse?_____

Was there an injury? (If so, give details)	**Yes/No**
Do you have nasal congestion, itching, sneezing?	**Yes/No**
Do you feel nausea or vomit in the morning?	**Yes/No**
Do you feel nausea or vomit with the headache?	**Yes/No**
Does the pain wake you at night?	**Yes/No**
Does the headache *start* while you are sleeping, so the first time you notice it is when you wake up in the morning?	**Yes/No**
Does light bother your eyes when you have a headache?	**Yes/No**
Does sound bother you when you have a headache?	**Yes/No**
Can you tell the headache is coming before you feel the pain? (If so, give details)	**Yes/No**

Is there any change in your thinking, speech or coordination? **Yes/No**
Do you get motion sickness? **Yes/No**
Do you get ice-cream headaches? (from cold food in your mouth) **Yes/No**
Are you taking any medicines? **Yes/No**
Do you use any supplements or herbal products? **Yes/No**

Do you have caffeine in your diet? (coffee, tea, iced tea, cola, chocolate) **Yes/No**
Do you eat three full meals each day? **Yes/No**
How much sleep do you get?
For females: Are the headaches related to your menstrual cycle? **Yes/No**

Does anyone in your family have headaches?_____

How are things going at school?
How are things going in your family?
Are there any new or unusual stresses?
Are you anxious? Do you feel depressed?