

Patient's Name: \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex:  Male  Female

Primary Care Physician: \_\_\_\_\_

Please answer the following questions to the best of your ability. This information will be used to assist in your child's care and may be used for study purposes. This is based on the original questionnaire that you filled out on the first visit.

**If multiple choices are available, please check all that apply.**

**Medication Allergies?**  Yes or  No

**Current Medications:** (please include *pill size* and *exact schedule*)

**Up to Date on Immunizations?**  Yes or  No

**Please Describe the Headaches:**

- Type (describe briefly): \_\_\_\_\_

- Does the child have *more than one type* of headache? \_\_\_\_\_

1. At what age do you think the headaches began? \_\_\_\_\_

2. How long have you had headaches? \_\_\_\_\_

3. Do you think anything caused the headaches to begin?  Yes  No  
What? \_\_\_\_\_

4. Does your child act different BEFORE the headache starts?  Yes  No  
 Tired  Irritable  Sunken Eyes  Flushed Face  "Not Right"  Mood changes

5. Are there triggers that can start a headache?  Yes  No  
 Stress  Less sleep  Food  Skipping Meals  Smells  Light  Noises  
 Weather  Menstruation  Concentrating  Caffeine  Chocolate  Other \_\_\_\_\_

6. How often does the headache occur?  
 <1/month  1-3/month  1/week  2-3/week  >3/week  Daily  
 Always  Other \_\_\_\_\_

Over the last three months, how many days PER MONTH did you have a headache? \_\_\_\_\_

When was your LAST headache? \_\_\_\_\_

7. Are there any warnings that the headache is going to start (auras)?  Yes  No  
 Visual  Auditory  Sensory  Smell  Taste Please explain: \_\_\_\_\_

8. Does your headache occur on one side of your head [ \_ ] and/or both sides [ \_ ]?  
On what parts of the head does the headache typically occur?  
 Both temples/sides  Left temple/side  Right temple/side  Front  Top  
 Back  Around eyes  Behind eyes  All over  Other \_\_\_\_\_

9. What is the pain of the headache like?  
 Throbbing  Squeezing  Stabbing  Pinching  Pressure  Burning  Sharp  
 Constant  Dull  "There"  Other \_\_\_\_\_

10. What symptoms can occur with the headache?  
 Nausea     Vomiting     Sensitivity to Light     Sensitivity to sound     Sensitivity to Smells  
 Lightheadedness     Spinning Sensation     Tearing eyes     Runny Nose     Decreased Appetite  
 Stomach Pain     Fatigue     Ringing in the Ears     Changes in vision  
 Confusion or Difficulty Thinking     Difficulty Walking/Using Arms/ Talking     Other \_\_\_\_\_
11. Do you experience any of these symptoms with many/most of your headaches?  
 Transient Blindness     Dark Blind Spots in your Vision     Worsening While Lying Down  
 Double Vision     Worse with Coughing or Going to the Bathroom
12. How many MINUTES does it take the headache to reach maximum intensity? \_\_\_\_\_
13. How many HOURS does the headache last?    Shortest: \_\_\_\_\_    Longest: \_\_\_\_\_    Average: \_\_\_\_\_
14. On average, how bad would you rate the headache (Please choose ONE)?  
 Mild     Moderate     Severe
- What is the severity on a scale of 0-10 (10 = worst)?  
 Mildest: \_\_\_\_\_    Worst: \_\_\_\_\_    Average: \_\_\_\_\_
15. During a bad headache: *Does your scalp hurt?*     Yes     No    *Does your neck hurt?*     Yes     No  
*Does your hair hurt?*     Yes     No    *Do your arms or legs hurt?*     Yes     No  
*Does it hurt to do the following:*     Comb or Brush Hair     Take a Shower (Hot/Cold)     Wash Face  
*Does it hurt to wear:*     Ponytail     Earrings     Necklace     Hat     Backpack  
 Glasses     Contacts     Headphones     Tight Clothing
- How soon after your headache starts do these symptoms begin? \_\_\_\_\_ minutes
16. Does the headache change your activity level (i.e. stop playing)?     Yes     No  
*Does activity or playing make the headache worse?*     Yes     No
- a. When you get a headache at school, at what level are you able to function?  
 100%     75%     50%     25%     0%
- b. When you get a headache playing at what level are you able to function?  
 100%     75%     50%     25%     0%
17. Is there a pattern to the headaches?     Yes     No  
 What pattern? \_\_\_\_\_
18. Does the headache occur at a particular time of day?     Yes     No  
 Waking up     Morning     Afternoon     Evening     Night     While asleep
19. Are the headaches associated with a particular season?     Yes     No    Which season? \_\_\_\_\_
20. Have other health care professionals seen you for headaches?     Yes     No  
 Who? \_\_\_\_\_
21. Have any studies or evaluations been performed?     Yes     No  
 MRI     CT/CAT scan     Sinus X-ray     EEG     Other \_\_\_\_\_
22. Has the *frequency* of the headaches changed?     Yes     No  
 If so, how? \_\_\_\_\_
23. Has the *severity* of the headaches changed?     Yes     No  
 If so, how? \_\_\_\_\_
24. Has the *duration* of the headaches changed?     Yes     No  
 If so, how? \_\_\_\_\_
25. Have the *associated symptoms* changed?     Yes     No  
 If so, how? \_\_\_\_\_

26. What over-the-counter medications is your child using for his/her headache?  
 Acetaminophen (Tylenol<sup>®</sup>)     Ibuprofen (Advil<sup>®</sup>/Motrin<sup>®</sup>)     Excedrin Migraine<sup>®</sup>     Aspirin  
 Naproxen (Aleve<sup>®</sup>)     Other \_\_\_\_\_
27. What other methods do you use to help headaches?  
 Sleep     Cold Compress     Hot Shower/Bath     Relaxation     Playing/Exercise  
 Eating     Other \_\_\_\_\_
28. Has anyone in the past every prescribed a DAILY medication to prevent headaches?     Yes     No  
 Which one(s)? \_\_\_\_\_

**HEADACHE DISABILITY**

The following questions try to assess how much the headaches are affecting day-to-day activity. Your answers should be based on the last three months. There is no “right” or “wrong” answers so please put down your best guess.

- 1a. How many full school days were missed in the last 3 months due to headaches? \_\_\_\_\_
- 1b. How many partial school days were missed in the last 3 months due to headaches (do not include full days counted in the first question)? \_\_\_\_\_
2. How many days in the last 3 months did you function at less than half your ability in school because of a headache (do not include days counted in the first two questions)? \_\_\_\_\_
3. How many days were you not able to do things at home (ie chores, homework, etc.) due to a headache? \_\_\_\_\_
4. How many days did you not participate in other activities due to headaches (i.e. play, go out, sports, etc.)? \_\_\_\_\_
5. How many days did you participate in these activities, but functioned at less than half your ability (do not include days counted in question number 4)? \_\_\_\_\_

**Healthy Habits**

**Drinking:** How much water do you drink a day? \_\_\_\_\_ # of 8 oz glasses OR \_\_\_\_\_ Total ounces  
 Do you drink caffeine?  Yes     No    How many days per week? \_\_\_\_\_  
 Are you drinking water in school? \_\_\_\_\_ With a water bottle? \_\_\_\_\_ Any problems? \_\_\_\_\_

**Exercise:** How many times a week are you exercising? \_\_\_\_\_

**Eating:** Are you skipping meals?     Yes     No    Which meals?     Breakfast     Lunch     Dinner  
 How many skipped meals per week? \_\_\_\_\_    Do you regularly eat vegetables?     Yes     No

**Sleeping:** How many hours of sleep are you getting a night? \_\_\_\_\_ Bedtime \_\_\_\_\_ Wake up time \_\_\_\_\_  
 Any difficulty sleeping?     Yes     No    Time in minutes to fall asleep \_\_\_\_\_  
 Do you get more headaches on a certain day of the week?     Yes     No  
 Which days?     Monday     Tuesday     Wednesday     Thursday     Friday     Saturday     Sunday

**Past Medical History:**

- Hospitalization or ER visit for headaches?     Yes     No  
 Date(s) \_\_\_\_\_
- Any other hospitalizations?     Yes     No  
 \_\_\_\_\_
- Any surgeries?     Yes     No  
 \_\_\_\_\_
- Accidents (especially head trauma)?     Yes     No  
 \_\_\_\_\_
- Illnesses (especially infection involving the brain)?     Yes     No  
 \_\_\_\_\_



**Birth History**

Mother's PREGNANCY: Any problems?  Yes  No \_\_\_\_\_

Mom's previous pregnancies/miscarriages \_\_\_\_\_ Other children \_\_\_\_\_

DELIVERY: Hospital and City of Birth: \_\_\_\_\_

Any problems?  Yes  No \_\_\_\_\_

Full term or early? \_\_\_\_\_ How long labor? \_\_\_\_\_

Breech? \_\_\_\_\_ Forceps? \_\_\_\_\_ C-section? \_\_\_\_\_

NEWBORN: Any problems?  Yes  No \_\_\_\_\_ Birth weight \_\_\_\_\_

Length \_\_\_\_\_ How long in hospital? \_\_\_\_\_ Intensive care?  Yes  No

**Other Medical Diagnoses?**  Yes  No

Seizures  ADD/ADHD  Asthma  Strokes  Depression

Anxiety  Other \_\_\_\_\_

Recent travel outside this country?  Yes  No

Exposures to toxic substances?  Yes  No

**Early Development:**

Any concerns with early development?  Yes  No

IF SO, then give approximate age at which following appeared: Or check  ALL NORMAL

Rolled Over \_\_\_\_\_ Sat Without Support \_\_\_\_\_

Walked \_\_\_\_\_ Toilet-Trained \_\_\_\_\_

Single Words \_\_\_\_\_ Talked in 3-Word Sentences \_\_\_\_\_

**Regular or Special** classes?

Any concerns with current school functioning?  Yes  No

Any therapies (PT, ST, OT, tutoring)? \_\_\_\_\_

Performance in school? \_\_\_\_\_ Behavior in school? \_\_\_\_\_

Reading level (if known) \_\_\_\_\_ Math level (if known) \_\_\_\_\_

Does your child have any of the following behavior concerns? (Check all that apply)

- |   |                                  |                                 |
|---|----------------------------------|---------------------------------|
| <input type="checkbox"/> Hyperactivity        | <input type="checkbox"/> At home | <input type="checkbox"/> School |
| <input type="checkbox"/> Impulsivity          | <input type="checkbox"/> At home | <input type="checkbox"/> School |
| <input type="checkbox"/> Moodiness            | <input type="checkbox"/> At home | <input type="checkbox"/> School |
| <input type="checkbox"/> Short Attention Span | <input type="checkbox"/> At home | <input type="checkbox"/> School |
| <input type="checkbox"/> Poor Judgement       | <input type="checkbox"/> At home | <input type="checkbox"/> School |
| <input type="checkbox"/> Distractibility      | <input type="checkbox"/> At home | <input type="checkbox"/> School |

**Family History (biological parents):**

Mother's name \_\_\_\_\_ Age: \_\_\_\_\_ Health \_\_\_\_\_

Occupation \_\_\_\_\_

Father's name \_\_\_\_\_ Age: \_\_\_\_\_ Health \_\_\_\_\_

Occupation \_\_\_\_\_

Brother(s) name \_\_\_\_\_ Age: \_\_\_\_\_ Health \_\_\_\_\_

Sister(s) name \_\_\_\_\_ Age: \_\_\_\_\_ Health \_\_\_\_\_

**WHO** in the family (if anyone) has similar headaches to the child? \_\_\_\_\_

If there is a **family history** of any of the following, please note:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Deafness                                      | <input type="checkbox"/> Depression                                     |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer  | <input type="checkbox"/> Drug Abuse/Alcoholism                          |
| <input type="checkbox"/> Seizures/Epilepsy   | <input type="checkbox"/> Tuberculosis                                  | <input type="checkbox"/> Intellectual disability or Learning Disability |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Hypertension                                  | <input type="checkbox"/> Brain tumor                                    |
| <input type="checkbox"/> Thyroid             | <input type="checkbox"/> Neuromuscular or other Neurological Disease   |   |
| <input type="checkbox"/> Sudden Death        | <input type="checkbox"/> Early Heart Attack or Stroke/What Age ? _____ |   |



		HEADACHES (Any type)	MIGRAINES	TENSION HEADACHE	SINUS HEADACHE	Other medical or mental health concerns
FATHER						
MOTHER						
Siblings	Age					
BROTHER						
SISTER						
Dad's Father						
Dad's Mother						
Mom's Father						
Mom's Mother						
Aunts and Uncles	#					
Dad's brothers						
Dad's sisters						
Mom's brothers						
Mom's sisters						
Other _____						

**Social History:**

Who lives in the home with the child currently? \_\_\_\_\_

Please note the *biological* parents' status:  Married/Living together  Divorced/Separated

If divorced/separated, do both parents have equal custody?  Yes  No

**Current School:**

Name of school: \_\_\_\_\_ Grade: \_\_\_\_\_

School type:  Public  Private  Charter  Home-schooled  College

**Review of Systems:**

If your child has any of the following concerns, please note if it is a problem *NOW* or in the *PAST*:

**General:**  Excessive Fatigue \_\_\_\_\_  Other \_\_\_\_\_

**Eyes:**  Blurred Vision \_\_\_\_\_  Squinting \_\_\_\_\_  Double Vision \_\_\_\_\_  
 Blind Spots \_\_\_\_\_  Loss of Vision \_\_\_\_\_  Crossed eyes \_\_\_\_\_  
 Odd Eye Movements \_\_\_\_\_  Recent Eye Examination \_\_\_\_\_

**ENT:**  Ringing in Ears \_\_\_\_\_  Hearing Problems \_\_\_\_\_  Ear Infections \_\_\_\_\_  
 Draining Ears \_\_\_\_\_  Allergies \_\_\_\_\_  Other \_\_\_\_\_

**Heart:**  Fainting \_\_\_\_\_  History of Murmur \_\_\_\_\_  Dizziness with Exercise \_\_\_\_\_  Other \_\_\_\_\_

**Lungs:**  Asthma \_\_\_\_\_  Wheezing \_\_\_\_\_  Pneumonia \_\_\_\_\_  
 Choking/Coughing \_\_\_\_\_  Other \_\_\_\_\_

**Musculoskeletal:**  RIGHT or  LEFT Handed  Clumsiness \_\_\_\_\_  Fractures \_\_\_\_\_  
 Muscle Weakness \_\_\_\_\_  Limping \_\_\_\_\_  Stumbling/Excessive Falling \_\_\_\_\_  
 Bone Pain \_\_\_\_\_  Abnormality or Deformity of Bones or Joints \_\_\_\_\_  Scoliosis \_\_\_\_\_  
 Other \_\_\_\_\_

**Gastrointestinal:**  Nausea \_\_\_\_\_  Vomiting \_\_\_\_\_  Diarrhea \_\_\_\_\_  
 Constipation \_\_\_\_\_  Blood in Stools/Black Stools \_\_\_\_\_  Other \_\_\_\_\_

- Do you think your child's *food choices* or *diet* contribute to the headaches?  Yes  No



**Genitourinary:**  Bladder or Kidney Infections \_\_\_\_\_  Blood in urine \_\_\_\_\_  
 Painful or Frequent Urination \_\_\_\_\_  Other \_\_\_\_\_

**Skin:**  Rashes \_\_\_\_\_  Birth marks \_\_\_\_\_  Eczema \_\_\_\_\_  Other \_\_\_\_\_

**Sleep problems:**  Sleeplessness \_\_\_\_\_  Teeth Grinding \_\_\_\_\_  
 Restless Sleeping \_\_\_\_\_  Excessive Daytime Sleepiness \_\_\_\_\_  
 Bed Wetting \_\_\_\_\_  Night Terrors/Nightmares \_\_\_\_\_  
 Sleepwalking \_\_\_\_\_  Snoring \_\_\_\_\_  Other \_\_\_\_\_

- Do you think that your child's headaches interfere with sleep?  Yes  No
- Do you think that *too little sleep* or *too much sleep* brings on your child's headaches?  Yes  No

**Neurological:**  Dizziness \_\_\_\_\_  Lightheadedness \_\_\_\_\_  Jerks \_\_\_\_\_  
 Abnormal Movements \_\_\_\_\_  Speech problems \_\_\_\_\_  Trouble Writing \_\_\_\_\_  
 Trouble Thinking \_\_\_\_\_  Loss of any Previously Acquired Developmental Functions \_\_\_\_\_  
 Convulsions \_\_\_\_\_  Seizures \_\_\_\_\_  Staring Spells \_\_\_\_\_  
 Prior Head Injury With or Without Loss of Consciousness \_\_\_\_\_  Other \_\_\_\_\_

**Psychiatric:**  Severe Mood Swings \_\_\_\_\_  Severe Behavioral Problems \_\_\_\_\_  
 Depression (current or previous) \_\_\_\_\_  Prior Trauma or Abuse \_\_\_\_\_  
 History of Seeing a Psychologist/Psychiatrist? \_\_\_\_\_  Other \_\_\_\_\_

**Heme/Lymph:**  Anemia \_\_\_\_\_  Swollen Lymph Nodes \_\_\_\_\_  Other \_\_\_\_\_

**Endocrine:**  Thyroid problems \_\_\_\_\_  Early Onset of Puberty (boys or girls) \_\_\_\_\_  
 Excessive sweating \_\_\_\_\_  Excessive Thirst \_\_\_\_\_  
 Excessive urination \_\_\_\_\_  Excessive Hunger \_\_\_\_\_  
 Always Too Cold \_\_\_\_\_  Always Too Hot \_\_\_\_\_  Other \_\_\_\_\_

**GIRLS:** at what age was the first period?  \_\_\_\_\_ Are they regular?  Yes  No  Not Sure

Are your headaches WORSE with your periods?  Yes  No  Not Sure  N/A

If you haven't had a period OR they just started, do you have monthly headaches?  Yes  No  Not Sure

\_\_\_\_\_ Days Severity \_\_\_\_\_ Duration \_\_\_\_\_

**Are there any other concerns that have not yet been addressed?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient/Legally Authorized Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient/Legally Authorized Representative**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Practitioner Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Time**

\_\_\_\_\_  
**Practitioner Printed Name**