NEW PATIENT TO HEADACHE CLINIC QUESTIONNAIRE:
Description of headaches: (If possible, to be filled out by the patient)

1. Who is accompanying you to the visit today? ________________________________
2. Have you been evaluated or treated for headaches by another provider? Who? ________________________________
3. When did you first start having headaches? ________________________________
4. On an average, how many days per week do you have headaches? ________________________________
5. Where on your head is the pain located? Forehead/ Temples/ Behind the Eyes/ Back of Your Head/ All Over the Head or Other? __________________________________________________________________________________
6. Does the pain usually occur on one side or both? ________________________________
7. Would you describe your pain as: Throbbing/Pulsating/ Squeezing / Pressure / Sharp / Stabbing / Dull or Other? __________________________________________________________________________________
8. Do your headaches usually occur at a certain time of day? (day /afternoon/night) ________________________________
9. Do your headaches ever wake you from sleep in the middle of the night? ________________________________
10. Headache intensity (on a scale of 1-10, ten being the worst pain ever) ________________________________
11. Do your headaches start out less intense and build to a greater intensity? ________________________________
12. How long do your headaches last? ________________________________
13. During your headache are you sensitive to light? ________________________________
14. During your headache are you sensitive to loud noises? ________________________________
15. During your headache are you sensitive to certain smells? ________________________________
16. Do you have nausea with your headaches? ________________________________
17. Do you have vomiting with your headaches? ________________________________
18. Is your headache gone after you vomit? ________________________________
19. Does sleep make your headaches better? ________________________________
20. Does stress or anxiety cause you to have headaches? ________________________________
21. Does sitting up or standing or transitioning from one position to another make your headache worse? Which position makes them worse? ________________________________
22. Have you noticed that anything causes your headaches, or is there a specific trigger for your headaches? ________________________________
NEW PATIENT TO HEADACHE CLINIC QUESTIONNAIRE:

Patient’s Name: _________________________________________

ANY AURA SYMPTOMS?

23. Do you experience any changes in your vision before/during your headaches? Spots in your vision: Black Spots/White Spots/Colored Spots/Double Vision/Blurry Vision? ______________________________________________________________

24. Do you feel dizzy during or before you have a headache? ______________________________________________________________

25. If so, does it feel like you are spinning around the room or the room is spinning around you? ______________________________________________________________

26. Do you have any ringing in your ears, hissing noises or buzzing in your ears during / before you have a headache? ______________________________________________________________

27. Do you have any numbness or tingling anywhere on your body before / during your headaches? ______________________________________________________________

28. Do you have weakness anywhere on your body before or during your headaches? If so, where on your body? ______________________________________________________________

29. Do you ever lose consciousness with your headaches? ______________________________________________________________

30. Do you ever have difficulty talking during or after your headaches? ______________________________________________________________

31. Have you ever lost control of your bowel or bladder during a headache? ______________________________________________________________

LIFESTYLE:

32. Who lives in your home with you? ______________________________________________________________

33. What time do you go to sleep each night during the week? ______________________________________________________________

34. What time do you wake up each morning during the week? ______________________________________________________________

35. Does this routine change on the weekends? ______ To What? ______________________________________________________________

36. Do you wake in the middle of the night and have difficulty going back to sleep? ______________________________________________________________

37. Do you snore regularly? ______________________________________________________________

38. How much water do you drink in a day? ______________________________________________________________

39. Do you eat three meals a day and two snacks? ______________________________________________________________

40. Do you eat a well-balanced diet including fruits and vegetables? ______________________________________________________________

41. Do you watch TV, play video games, text, or are you on the computer (combined) more than two hours a day? ______________________________________________________________

42. Do you drink the super concentrated caffeinated drinks such as Monster® drinks or Red Bull® or Mountain Dew®? ______________________________________________________________

43. Do you play any sports? ______________________________________________________________

44. How do you exercise regularly? ______________________________________________________________

45. What do you do for fun? ______________________________________________________________

46. What grade are you in? ______________________________________________________________

47. What are your grades like? ______________________________________________________________

48. What is the name of your school? ______________________________________________________________

Please return completed form to the medical assistant or nurse.

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NEW PATIENT TO HEADACHE CLINIC QUESTIONNAIRE:

Patient’s Name: _________________________________________

49. Are you currently experiencing feelings of Sadness? Tearfulness? Withdrawal? Hopelessness or Helplessness? __________

50. Has there been any new Family/School/Work Stress? If so, describe situation? _________________________________________

51. Do you smoke? ________________ Do you use any illegal drugs? __________

52. Do you drink alcohol? __________________________________________

53. For Girls: Do you have your menstrual cycle? __________ Is your cycle regular? _________________________________
   Is there any correlation that you noted between your menses and your headaches? _______________________________
   Are you on birth control? __________ Are you sexually active? ___________ Do you use protection? __________

WHAT DO YOU DO WHEN YOU GET A HEADACHE?

54. Do you take Advil® Motrin® Tylenol® Aleve® Excedrin® or other? __________________________________

55. How many days of the last 2 weeks did you take any of the above medications: _________________________________

56. Have you been tried on any preventive medications for your headaches in the past? _____________________________

HOW HAVE YOUR HEADACHES AFFECTED YOUR LIFE?

57. How many full days of school have you missed in the last 3 months? _________________________________

58. How many times have you gone to the school nurse in the last 3 months? _________________________________

59. How many partial days of school have you missed in the last 3 months? _________________________________

60. How many days in the last 3 months were you unable to do things at home (chores, homework, etc.) due to headaches? ______

61. How many days were you not able to participate in other activities (play, go out, sports) due to your headaches? ______

62. How many days did you participate in these activities, but function at less than half your ability? __________________

63. How many times in the last 3 months have you visited an emergency department for headaches? __________________

64. How many times in the last 3 months have you had to be admitted to the hospital for headache treatment? __________

Any additional comments: _____________________________________________________________________________

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NEW PATIENT TO HEADACHE CLINIC QUESTIONNAIRE:

Patient’s Name: _________________________________________

BIRTH HISTORY: (FOR PARENT TO FILL OUT)

1. How are you related to this child biologically? _______________________________________________________
2. How old was Mom at the time of this pregnancy? _____________________________________________________
3. Was the pregnancy with this child full term? _______________________________________________________
4. How much did your child weigh at birth? ___________________________________________________________
5. How many times has Mom been pregnant? _________________________________________________________
6. What number pregnancy is this child? _____________________________________________________________
7. Have you had any miscarriages? ________________________________________________________________
8. Was Mom utilizing drugs or alcohol during your pregnancy? ____________________________________________
9. Did Mom receive pre-natal care? ________________________________________________________________
10. Was Mom on any medications during the pregnancy? ________________________________________________
11. What medication was Mom on? _________________________________________________________________
12. Did Mom have any complications with the pregnancy? ______________________________________________
13. Was this child born vaginally or via C-Section? ____________________________________________________
14. Did your child have any complications breathing after delivery? _________________________________
15. Did your child have jaundice or infections after delivery? __________________________________________
16. Did your child have the need for oxygen or a ventilator after delivery? __________________________
17. Did your child require surgery soon after birth? ___________________________________________________
18. Did your child have any seizures soon after birth? ________________________________________________
19. How many days after delivery was your child sent home from the hospital? ________________________

DEVELOPMENT: (FOR PARENT TO FILL OUT)

20. Did your child achieve all of their developmental milestones on time? _____________________________
21. If not, in what areas did they need extra help and have they caught up at this time? __________________

22. Does your child need any added help in school, an IEP or a 504 plan? ____________________________
23. Has your child ever needed early intervention for physical therapy, occupational therapy, or speech therapy? ____________
NEW PATIENT TO HEADACHE CLINIC QUESTIONNAIRE:

Patient’s Name: _________________________________________

REVIEW OF SYSTEMS: (FOR PARENT TO FILL OUT)

24. Does this child have Asthma, Allergies or Eczema? ____________________________________________________________
25. Does your child have ADHD, ADD or Anxiety concerns? __________________________________________________________
26. Does your child get Motion Sickness? ______________________________________________________________________________
27. What other conditions has your child been previously diagnosed with? ________________________________________________
28. Has this child had any recent acute intense illnesses or injury (Lyme, Mono, Concussion, Motor Vehicle Accident, etc.?) __________
29. Has your child or their family members ever been the victim of abuse? ________________________________________________
30. Was the abuse physical, sexual or mental? ________________________________
31. Is there any connection between the onset of the headaches and the above? _____________________________________________
32. When was your child’s last dental evaluation? ________________________________
33. When was your child’s last eye examination by an ophthalmologist? ________________________________
34. Does your child wear glasses? For what correction? ______________________________________________________________
35. Has your child ever had cardiac arrest or stopped breathing? When? ______________________________________________________
36. Has your child ever had meningitis or encephalitis? ______________________________________________________________
37. Has your child ever had a head injury that resulted in loss of consciousness? When? _________________________________

HOSPITALIZATIONS & SURGERIES: (FOR PARENT TO FILL OUT)

38. Has your child ever been hospitalized over night? When? For what? ________________________________________________

MEDICATIONS: (FOR PARENT TO FILL OUT)

40. What medications is your child on currently: _________________________________________________________________
41. Is your child up to date on all of their immunizations? __________________________________________________________
42. Is your child allergic to any medications? _________________________________________________________________
43. If so, what is the reaction? ________________________________________________________________

Please return completed form to the medical assistant or nurse.
**NEW PATIENT TO HEADACHE CLINIC QUESTIONNAIRE:**

Patient’s Name: ______________________________

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**FAMILY HISTORY: PLEASE INDICATE WHICH FAMILY MEMBERS AFTER EACH QUESTION. (FOR PARENT TO FILL OUT)**

44. Is there a family history of Headaches or Migraines? ___________________________________________________

45. Is there a family history of Vascular Disease (Stroke before 60 yrs. of age, deep vein thrombosis, clotting disorder)? ______

46. Is there a family history for Epilepsy or Seizures? _______________________________________________________

47. Is there a family history of Thyroid Disease? ____________________________________________________________

48. Is there a family history of Autoimmune Disease? ________________________________________________________

49. Is there a family history of Polycystic Ovarian Disease? __________________________________________________

50. Is there a family history of Kidney Disease, Kidney Stones? ______________________________________________

51. Is there a family history of Neurofibromatosis, Tuberous Sclerosis? _______________________________________

52. Is there a family history of Multiple Sclerosis? __________________________________________________________

53. Is there a family history of Anxiety Disorder? ________________ Obsessive Compulsive Disorder? _____________

   ADD or ADHD? ______________ Bipolar Disease? ______________ Depression? _________________

   Schizophrenia? ______________

54. Is there a family history of Obstructive Sleep Apnea? ____________________________________________________

55. Is there a family history of Neuromuscular Disease? ______________________________________________________

56. Is there a family history of High Cholesterol? __________________________________________________________

57. Is there a family history of Diabetes? _________________________________________________________________

58. Is there a family history of Heart Disease? ______________________________________________________________

59. Has anyone in the family died from Sudden Cardiac Death? ______________________________________________

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**HAS YOUR CHILD HAD ANY PREVIOUS TESTS DONE? (FOR PARENT TO FILL OUT)**

60. Has your child had an MRI, CT, EKG, EEG or Blood work done in evaluation of their headaches? _________________

   ________________________________________________________________________________________________

61. What were the results of these studies: __________________________________________________________________

   ________________________________________________________________________________________________

   Any additional comments/concerns: __________________________________________________________________

   ________________________________________________________________________________________________

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THIS SECTION FOR PROVIDER ONLY:

Patient’s Name: _________________________________________

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<tr>
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PHYSICAL EXAM ABNORMALITIES:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

FAMILY HISTORY CONCERNS:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

NEUROLOGICAL EXAM ABNORMALITIES:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
THIS SECTION FOR PROVIDER ONLY:

Patient’s Name: _______________________________________

PLAN:

1. _______________________________________________________
2. _______________________________________________________
3. _______________________________________________________
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