

Headache Questionnaire

McKenzie Pediatrics

Child's Name: _____ Birth Date: _____

Questionnaire Completed By: _____ Today's Date: _____

1. At what age did the headaches begin? _____
2. How often do they occur? _____
3. How long do they usually last? _____
4. Are they getting worse over time? _____
5. Are they getting more frequent? _____
6. Where in the head does the pain begin? _____
7. Does the pain spread to other locations? _____
8. Does the pain ever awaken from sleep? _____
9. Does the pain interfere with normal activities? _____
10. What is the pain like? (throb, pressure, sharp...) _____
11. When do they most occur? (morning, school evening...) _____
12. What worsens the pain? (coughing, bending, light, noise...) _____
13. Are there changes in vision before, during, or after? _____
14. If so, describe these changes: _____
15. Are there any changes in personality before or after? _____
16. If so, describe these changes: _____
17. What helps the pain? (rest, ibuprofen, Tylenol...) _____
18. What seems to bring on the pain? _____
19. Is there any nausea or vomiting before, during, or after? _____
20. Do any of these symptoms happen before the pain?: mood changes, numbness, weakness, tingling, irritability, tremors, unusual odors
21. Does anyone else in the family suffer from headaches? _____
22. What types of headaches do they have? _____
23. Are there any nervous system diseases in the family? _____
24. Have you (the child) had any previous head injuries or trauma? _____
25. Have you (the child) had any previous seizures? _____

Any additional information you'd like to offer? _____

Finally, on the back side of this paper, please have your child draw a picture of themselves when they have a headache. Thank you!