

Headache Questionnaire

McKenzie Pediatrics 2010

Thank you for completing this questionnaire. Your detailed answers will be very helpful in determining the cause of your child's headaches.

1. How and when did your child's headaches begin?

2. What is the location(s) of your child's headaches?

3. How often do they occur? _____
4. Are they getting worse over time? _____
5. What is the quality of the pain (pounding, squeezing, stabbing, or other)? _____
6. How long do they last, on average? _____
7. Are there any other symptoms associated with the headache (nausea, vomiting, dizziness, numbness, weakness, or other)? _____
8. What makes the headache better? _____
9. What makes the headache worse? _____
10. Do any activities, medications, or foods tend to cause or aggravate your child's headaches?

11. What does your child do when a headache occurs? _____
12. Does ibuprofen (Motrin™ or Advil™) or acetaminophen (Tylenol™) help to ease or eliminate the headache? _____
13. Do the headaches occur under any special circumstances or at any particular time?

14. Does your child have any underlying medical problems? _____
15. Is your child on any daily medications (not including vitamins or fluoride)? If so, please list the medications: _____
16. Was there any head injury associated with the onset of the headaches? _____
17. Has your child ever had seizures/convulsions, even if not associated with a headache? _____
18. Since the headaches began, have there been any changes in walking, balance, vision, handedness, behavior, speech, or school performance? _____
19. Have there been any episodes where the headache occurred in the middle of the night, or first thing upon awakening? _____
20. Has your child experienced any vomiting associated or not with the headaches? _____
21. Are there warning signs that your child reports that (s)he can tell that a headache is coming?

22. Does anyone in your immediate family suffer from migraine headaches (presently, or as a child)?

23. Does your child get enough sleep? _____
24. Does (s)he snore while asleep? _____ Is (s)he a restless sleeper? _____
25. Does your child have a television or video game player in his or her bedroom? _____
26. Does your child drink enough fluids throughout the day, in general? _____
27. Does your child suffer from seasonal allergies? _____
28. Are there any current stresses in your child's home or school life? _____