Headache Evaluation Form

Client #_____ Name _____ Age_____

When you have headaches, how often do you…… (Circle one answer per question)

1. Feel them coming on before they become headaches?	Never	Rarely	Usually	Always
2. Have moderate to severe pain?	Never	Rarely	Usually	Always
3. Have pulsating, pounding, or throbbing pain?	Never	Rarely	Usually	Always
4. Have worse pain on one side of your head?	Never	Rarely	Usually	Always
5. Have worse pain when you move, bend over or walk stairs?	Never	Rarely	Usually	Always
6. Have nausea?	Never	Rarely	Usually	Always
7. Have vomiting?	Never	Rarely	Usually	Always
8. Feel bothered by light?	Never	Rarely	Usually	Always
9. Feel bothered by sound?	Never	Rarely	Usually	Always
10. Need to limit or avoid daily activities?	Never	Rarely	Usually	Always
11. Want to lie down in a quiet, dark room?	Never	Rarely	Usually	Always
12. See zigzag lines, spots, or light flashes?	Never	Rarely	Usually	Always

To give your healthcare provider more complete information, please answer these additional questions:

1. Do any immediate family members also suffer from headaches?	Yes	No
2. In your lifetime, have you had at least 5 headaches with the symptoms noted above?	Yes	No

3. At what age did you first experience these headaches?_____
4. On average, how often do you get these headaches? _____
5. Which medicine(s) do you take for your headaches? _____

Check all of the statements that are true:

1. My headache medicine does not make me pain free. ____
2. My headache medicine does not treat other symptoms (e.g., nausea, sensitivity to light). ____
3. I take my headache medicine more than 2 or 3 times per week. ____
4. My headache medicine makes me drowsy. ____
5. I take more than one kind of medicine for my headaches. ____
6. My headache may last 4 to 72 hours (untreated or unsuccessfully treated). ____

Check any of the following that ever bring on one of these headaches:

___Intense lights, smells, or sounds
___Weather changes
___Allergies or sinus pain/pressure
___Stress or tension
___Monthly menstrual cycle/hormonal changes
____Too little sleep or too much sleep
____Missed meals
____Lack of caffeine or too much caffeine
____Changes in mood/excitement
____Foods or alcoholic beverages

Client's Signature:_____Date:_____

TO BE COMPLETED BY STAFF
Assessment:

_____

Clinician Signature Date Agency Name

Adapted from: The American Journal of Nurse Practioners April 2004 Vol. 8 No. 4