Renown CHILDREN'S HOSPITAL
Renown Children's Hospital • 1155 Mill St. • Reno, NV 89502
775-982-KIDS (5437) • BestMedicineNews.org/kids • renown.org/children

Initial Pediatric Headache Questionnaire

Patient name _____

Age: _____ Gender: _____ Handedness: R L Uses Both

Person filling out the questionnaire / relationship to patient: _____

Please have your child answer the following questions regarding their headaches:

Headache History

When did the headaches first start?_____ Since starting, have they changed? ___Yes ___ No

What was the initial cause? _____ Unknown _____

Do you have more than one type of headache? ◯ YES ◯ NO (If yes, answer questions for *worst* headache type, then describe your second / other type(s) on last page)

Onset

When does the headache start?

◯ Upon waking up ◯ Morning ◯ Afternoon ◯ Evening ◯ Middle of the night ◯ Onset varies

Does the headache wake you up in the middle of the night? ◯ Yes ◯ No

If yes, how frequently? ◯ <1 per month ◯ 1-3 per month ◯ 1 per week ◯ 2-3 per week

◯ 3-6 per week ◯ Nightly

Does the headache usually start abruptly or build slowly? _____

Frequency

How often do you have a severe/debilitating (You have to lay down) headache?

Day _____ Week _____ Month _____

How often do you have a mild/moderate headache? Day _____ Week _____ Month _____

How long has it been this frequent? _____

Does the child have headaches on weekends / holidays? ◯ YES ◯ NO

In the last 90 days, the headaches are (check all that apply):

_____ More frequent _____ Less frequent _____ More severe _____ Less severe

_____ More continuous _____ Less continuous _____More predictable _____ Less predictable

_____ Last longer _____ Do not last as long _____Different in quality

Duration

How long does the shortest headache last? (Provide number) ____minutes ____hours ____days

How long does the longest headache last? (Provide number) ____minutes ____hours ____days

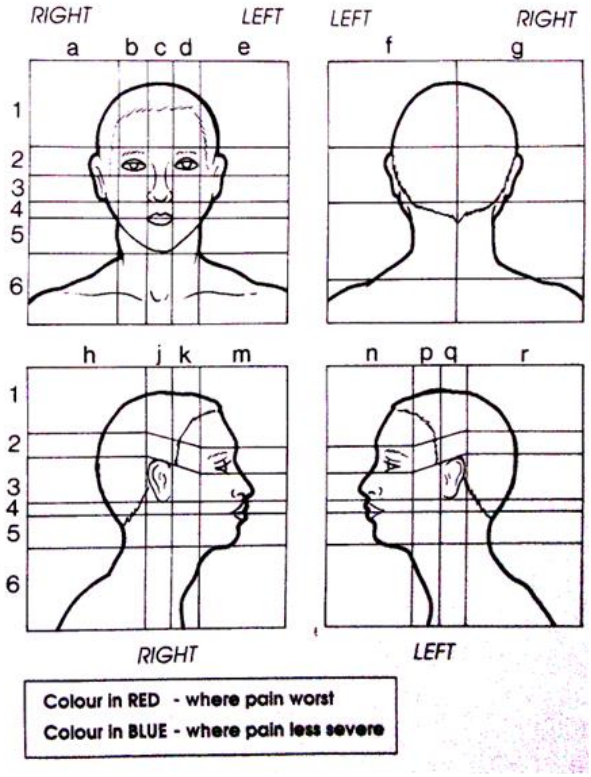
How long does the average headache last? (provide number) ____minutes ____hours ____days

Location

Where is your headache pain? (Check all that apply):

◯ Forehead: R L Both ◯ Left side of head ◯ Right side of head ◯ Both sides of head

◯ Back of head ◯ Neck ◯ Around eyes: R L Both ◯ Behind eyes ◯ All over ◯ Top of head



Character

What does the pain feel like?

◯ Throbbing ◯ Pounding ◯ Squeezing ◯ Stabbing ◯ Pinching ◯ Pressure ◯ Burning

◯ Sharp ◯ Dull/Aching ◯ Numbness ◯ Shooting ◯ Other:_____

Severity

On a scale of 0 to 10, what is the severity of your headache? (0 = no pain; 10 = worst pain imaginable)

Your pain right now: _____ Your pain at its best: _____

Your typical headache: _____ Your headache at its worst: _____

Have you ever been to an emergency room because of your headache?◯ YES◯ NO

If yes, how many times in the past year? _____ In the past month? _____

Have you ever stayed overnight in a hospital because of your headache?◯ YES◯ NO

Have you missed school due to the headache?◯ Yes◯ No

If yes, how many times in the past year?_____

Triggers

What brings on your headache? (Check all that apply):

◯ Skipping meals◯ Hunger◯ Dehydration◯ Chocolate◯ Caffeine◯ Lunch meat

◯ Other food: _____◯ Food sensitivities/allergies◯ Coughing◯ Talking

◯ Chewing/ Clenching teeth◯ Exercise◯ Other physical exertion:_____

◯ Menstrual cycle◯ Oral contraceptives◯ Stress at school◯ Stress at home

◯ Other stress:_____◯ Allergies◯ Weather changes◯ Heat◯ Altitude◯ Sunlight

◯ Smells/Perfumes ◯ Light◯ Noise◯ Riding in the car◯ Sinus problems◯ Reading

◯ Sleeping too little/fatigue◯ Sleeping too much◯ Medications:_____

◯ Other:_____

Premonitory Symptoms (Symptoms that start before the headache) (Check all that apply)

◯ Blurred vision◯ Double vision◯ Loss of vision on one side◯ Total blindness

◯ Tunnel vision◯ Seeing spots, lines, shapes◯ Other vision changes:_____ _____

◯ Numbness◯ Weakness◯ Paleness◯ Dizziness◯ Fatigue/tiredness◯ Hyperactivity

◯ Increased appetite◯ Decreased appetite◯ Mood swings/irritability◯ Nasal congestion

◯ Other symptom:_____

Associated Symptoms

What symptoms do you have ***with*** your headache? (Check all that apply)

◯ Nausea◯ Vomiting◯ Sensitivity to light◯ Sensitivity to sound◯ Sensitivity to smells

◯ Dizziness/lightheadedness◯ Teary eyes◯ Runny nose/nasal congestion

◯ Decreased appetite◯ Stomach pain◯ Ringing in your ears/hearing abnormalities◯ Sweating

◯ Changes in vision◯ Double vision◯ Confusion ◯ Irritability◯ Tiredness◯ Swelling

◯ Anxiety◯ Numbness/tingling; location:_____◯ Balance problems◯ Speech problems

◯ Unusual sensations◯ One-sided weakness; side:____◯ General weakness◯ Unconscious

◯ Loss of strength to limbs◯ Tightness in neck/back◯ Pain in neck/back◯ Bladder problems

◯ Bowel problems◯ Memory problems◯ Attention/Concentration problems◯ Chest pain

◯ Unusual smell/taste◯ Jaw pain/Dental pain◯ Cold hands or feet◯ Loss of sensation to limbs/face◯ Fever

Aggravating Factors

What makes your headache worse?

◯ Physical activity◯ Standing up ◯ Laying down◯ Straining (laughing/coughing/ sneezing)

◯ Sitting ◯ Bending◯ Lifting◯ Reaching◯ Reaching overhead◯ Stress◯ Lack of sleep

Relieving Factors

What makes your headache better? (Check all that apply)

◯ Laying down◯ Dark, quiet room◯ Hot compress◯ Cold compress/Ice

◯ Sleep◯ Physical activity/exercise◯ Standing◯ Walking◯ Stretching◯ Massage

◯ TENS◯ Compression◯ Traction◯ Biofeedback◯ Vomiting

◯ Medication:_____◯ Other:_____

Habits

DIET:

Do you skip meals?◯ Breakfast◯ Lunch◯ Dinner◯ None

How much do you drink per day?

◯ Water _____times per day; _____ Total oz.◯ Juice ____times per day; _____ Total oz.

◯ Coffee _____times per day; _____ Total oz. ____ Caffeinated _____ Decaf

◯ Soda _____times per day; _____ Total oz. ____ Caffeinated _____ Decaf

◯ Sports drinks ____times per day; ____ Total oz.◯ Milk _____times per day; _____ Total oz.

◯ Energy drinks _____times per day; _____ Total oz.◯ Other:_____

OTHER:

Does your child smoke?◯ Yes◯ No If yes, how often? _____ times per week

Use recreational drugs?◯ Yes◯ No If yes, how often? _____ times per week

Use alcohol?◯ Yes◯ No If yes, how often? _____ times per week

SLEEP:

When do you go to bed on weekdays? _____PM/AM

When do you go to bed on the weekend? _____PM/AM

When do you wake up on weekdays? _____AM/PM

When do you wake up on weekends? _____AM/PM

Average # hours of sleep per night: _____

Do you:

Take a daytime nap? ◯ YES◯ NO

Have trouble falling asleep? ◯ YES◯ NO

Have trouble staying asleep? ◯ YES◯ NO

Times per night your child wakes up: _____

Snore? ◯ YES◯ NO

Grind your teeth? ◯ YES◯ NO

Stop breathing? ◯ YES◯ NO

Talk in your sleep? ◯ YES◯ NO

Sleep walk? ◯ YES◯ NO

Have restless sleep? ◯ YES◯ NO

Have nightmares? ◯ YES◯ NO

Cry out while sleeping or awaken screaming?◯ YES ◯ NO

Wet the bed? ◯ YES◯ NO Frequency: _____times per week

Wake feeling well-rested? ◯ YES◯ NO

Wake up unusually early in the morning? ◯ YES◯ NO

Wake up with a headache? ◯ YES◯ NO

Do you use any of the following before bedtime?

◯ TV◯ Music◯ Read◯ Talk on phone/text◯ Computer/tablet/smart phone◯ Video games

Do you use any of the above while in bed? Explain:_____

PHYSICAL ACTIVITY:

Do you exercise?◯ YES◯ NO Type of exercise: _____ Frequency:_____

Do you play any sports?◯ YES◯ NO Sport:_____ Frequency:_____

Current Medical/Social History

Have you had any of the following in the past year?

◯ Memory problems◯ Changes in vision◯ Problem with coordination◯ Problem with balance

◯ Dizziness upon standing◯ Fainting◯ Change in weight? _____ pounds lost/gained (circle one)

◯ Behavior problems◯ Personality changes◯ Feeling sad or depressed◯ Crying easily

◯ Acting more irritable than usual◯ Eating poorly◯ Overeating◯ Parental separation/divorce

◯ Job change◯ Move◯ Diagnosis of chronic or major illness◯ Death of family member/loved one

◯ Close relative with diagnosis of chronic or major illness◯ Conflict with family member/friend

◯ Difficulty in school◯ Motion/car sickness◯ Head injury◯ Jaw pain/Dental pain

◯ Anxiety/panic Attacks ◯ Epilepsy / Seizures: Describe: _____

◯ Sinus infections/Sinus pain◯ Neck injury◯ Meningitis◯ Brain tumors/infections◯ Eye Problems

◯ Fainting ◯ Other recent stressors:_____

◯ Currently working?◯ Yes◯ No Job satisfaction?◯ Excellent◯ Good◯ Fair ◯ Poor

Family History

Does anyone in your family have/had the following? (Parents, Grandparents, siblings, Aunts, Uncles)

Migraines?	◯ YES◯ NO	If yes, who?_____
Headaches? (Even in childhood)	◯ YES◯ NO	If yes, who?_____
Motion sickness?	◯ YES◯ NO	If yes, who?_____
Dizziness/fainting?	◯ YES◯ NO	If yes, who?_____
Anxiety?	◯ YES◯ NO	If yes, who?_____
Depression?	◯ YES◯ NO	If yes, who?_____
Bad mood swings?	◯ YES◯ NO	If yes, who?_____
Psychiatric hospitalizations?	◯ YES◯ NO	If yes, who?_____
Use of street drugs?	◯ YES◯ NO	If yes, who?_____
Epilepsy?	◯ YES◯ NO	If yes, who?_____
Early heart disease? (Under 45)	◯ YES◯ NO	If yes, who?_____

Early strokes? (Under 45) ◯ YES◯ NO If yes, who?_____

Fainting? ◯ YES◯ NO If yes, who?_____

Repeated stomach pains? ◯ YES◯ NO If yes, who?_____

Any nervous diseases? ◯ YES◯ NO If yes, who?_____

Diagnostic Evaluation

When was your last eye exam? _____ (Please provide date)

What workup has been done previously?

◯ CT scan: Date_____ Results? _____ Where? _____

◯ MRI scan: Date_____ Results? _____ Where? _____

◯ Plain X-ray Date_____ Results? _____ Where? _____

◯ Dental exam: Date_____ Results? _____ Where? _____

◯ Spinal tap: Date_____ Results? _____ Where? _____

◯ Allergy testing: Date_____ Results? _____ Where? _____

◯ Blood tests: Date_____ Results? _____ Where? _____

◯ EMG/Nerve conduction: Date _____Results? _____ Where? _____

Treatment

What medications are you ***currently taking to prevent*** headaches?

Name: _____ Dose: _____ Helpful? Yes No

_____ Dose: _____ Helpful? Yes No

What medications are ***you currently taking*** at the time of a headache to relieve/stop it?

Name: _____ Dose: _____ Helpful? Yes No

_____ Dose: _____ Helpful? Yes No

What medications have you used ***in the past to prevent*** headaches?

Name: _____ Dose: _____ Helpful? Yes No

_____ Dose: _____ Helpful? Yes No

What medications have you used ***in the past to*** relieve/stop the headaches?

Name: _____ Dose: _____ Helpful? Yes No

_____ Dose: _____ Helpful? Yes No

How often do you take any medication for your headache, including over-the-counter medications?

◯ <5 days/month ◯ 6-10 days/month ◯ 11-15 days/month ◯ >15 days/month

What vitamins, herbal medications, or other supplements have you used for your headaches?

_____

_____

List any **medication allergies** your child has: _____

Is he/she allergic to Latex? _____ Yes _____ No

What alternative therapies have you tried for your headaches?

◯ Massage: _____ times per week

◯ Chiropractor: _____ times per week

◯ Biofeedback: _____ times per week

◯ Physical/occupational therapy: _____ times per week

◯ Relaxation/Stress management: _____ times per week

◯ Ayurvedic medicine

◯ Naturopathy

◯ Aromatherapy

◯ Other:_____

Second Headache Type

If you have more than one type of headache, please describe that headache on the back of this page.

Please indicate any additional information you feel would be helpful in treating your child:

To be filled out by the doctor only:

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

PedMIDAS

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 are no "right" or "wrong" answers so please put down your best guess.

1. **How many full school days or school were missed in the last 3 months due to headaches?** _____

2. **How many partial days of school were missed in the last 3 months due to headaches (do not include full days counted in the first question)?** _____

3. **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)?** _____

4. **How many days were you not able to do things at home (i.e., chores, homework, etc.) due to a headache?** _____

5. **How many days did you not participate in other activities due to headaches i.e., play, go out, sports, etc.)?** _____

6. **How many days did you participate in these activities, but functioned at less than half your ability (do not include days counted in the 5th question)?** _____

Total PedMIDAS Score _____

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____