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

Name: _______________________________ 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

Name: _______________________________ Dose: ________ Helpful? Yes No

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

Name: _______________________________ Dose: ________ Helpful? Yes No
What medications have you used in the past to relieve/stop the headaches?

Name: _______________________________ Dose: ________ Helpful? Yes No
Name: _______________________________ 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:

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

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 __________
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?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all sure</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it's hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add the score for each column:

Total Score (add your column scores) =

# 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)

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

Add columns: ______________________ + ______________________ + ______________________ + ______________________

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

<table>
<thead>
<tr>
<th></th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>__________________</td>
<td>__________________</td>
<td>__________________</td>
<td>__________________</td>
</tr>
</tbody>
</table>

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