

Name: _____

Date: _____

Forest* Headache Questionnaire

Answer all questions, yes or no, with a check mark

YES**NO**

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you have an idea what may be causing your headaches? (Whiplash, Diabetes, High blood pressure, Eye strain, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Did this same type of headache occur before? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you have more than one type of headache? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Is the headache pain so intense that sometimes it becomes unbearable? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do your headaches occur during stressful tension or nervousness at home, at work, or during social occasions? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do your neck, shoulder muscles or head junction feel tight and painful during the headache? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Is your headache pain dull and steady, like an intense constant pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Does your headache feel like a tight band around your head? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you usually have (1) or more headaches per week? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do your headaches occur during the day? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Does your Mother, Father, or any blood relative have similar headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Does exertion (lifting, running, straining, sex) affect your headache? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Does nausea and/or vomiting occur before or during your headache? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have any changes in vision (flashing lights, sensitivity to light, spots, blurred vision, etc.) before or during your headache? |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Does your headache usually start on one side of the head? |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Does your headache throb and pulsate or feel like it is pounding? |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Do your headaches usually occur during the night or upon awakening? |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Do your headaches usually occur during weekends and holidays? |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. (Females Only) Is your headache associated with your menstrual cycle? |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. Do you have watering of the eye on the affected side of the headache? |
| <input type="checkbox"/> | <input type="checkbox"/> | 21. Do alcoholic drinks cause or aggravate your headache? |
| <input type="checkbox"/> | <input type="checkbox"/> | 22. Does chocolate, cheese, milk, nuts, chinese food, or any other food cause or worsen your headache? |
| <input type="checkbox"/> | <input type="checkbox"/> | 23. Do you have any hearing problems - noise, drainage or stuffiness in either ear? |
| <input type="checkbox"/> | <input type="checkbox"/> | 24. Have you noticed any paralysis, muscle weakness, numbness, swallowing problems or speech changes during your headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | 25. Do you have any facial pain, aching jaws, stuffiness or congested sinuses along with your headache? |
| <input type="checkbox"/> | <input type="checkbox"/> | 26. Has it been over (18) months since you last visited a dentist? |
| <input type="checkbox"/> | <input type="checkbox"/> | 27. Have you had tests for headache? (x-ray, brain scan, injections, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you used any previous headache medication? List all medications on the back of this form. |