



Daleville Community Schools
14300 W 2nd Street
Daleville, IN 47334
P: (765) 378-3329
F: (765) 378-3649
www.daleville.k12.in.us

Headache Questionnaire

Student Name

Grade

Date

What year did your current headaches begin? _____

When was your last headache? _____

How many headaches do you have each month? _____

How long do they last? _____

How would you describe the pain of your most serious headaches (check all that apply):

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> throbbing | <input type="checkbox"/> pressure-like | <input type="checkbox"/> stabbing |
| <input type="checkbox"/> pulsating | <input type="checkbox"/> aching | <input type="checkbox"/> electric-like |
| <input type="checkbox"/> dull | <input type="checkbox"/> sharp | <input type="checkbox"/> vise-like |

Are your headaches **brought on** by (check all that apply):

- | | | | |
|-----------------------------------|---|---|--|
| <input type="checkbox"/> smoke | <input type="checkbox"/> hunger | <input type="checkbox"/> bright light | <input type="checkbox"/> change in weather |
| <input type="checkbox"/> noise | <input type="checkbox"/> glare | <input type="checkbox"/> lack of sleep | <input type="checkbox"/> relaxation after stress |
| <input type="checkbox"/> exercise | <input type="checkbox"/> odors | <input type="checkbox"/> too much sleep | <input type="checkbox"/> your periods |
| <input type="checkbox"/> stress | <input type="checkbox"/> food additives | <input type="checkbox"/> certain foods | <input type="checkbox"/> hormonal changes |

Do your headaches occur on any particular day of the week or time of day? _____

Do you have any warning signs before the start of a headache? _____

Yes

No

Describe: _____

Check any of the following **symptoms** you have with your headaches:

- | | | | |
|------------------------------------|-----------------------------------|--|------------------------------------|
| <input type="checkbox"/> nausea | <input type="checkbox"/> numbness | <input type="checkbox"/> neck pain | <input type="checkbox"/> confusion |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> weakness | <input type="checkbox"/> light sensitivity | |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> fever | <input type="checkbox"/> noise sensitivity | |

Have you ever been treated for headaches? _____
Yes *No*

If yes, with what are you currently being treated? _____

Parent Signature: _____