PHOENIX CHILDREN'S Medical Group

HEADACHE FOLLOW-UP QUESTIONNAIRE

Apply Patient Label

Patient's Name: _____ Date of Birth_____/_____/_____ Today's Date_____/_____/_____

Please answer the following questions to the best of your ability. This information will be used to assist in your child's care and may be used for study purposes. This is based on the original questionnaire that you filled out on the first visit.
If multiple choices are available, please check all that apply.

1. Have the headaches changed compared with your first visit?
   ☐ Better ☐ Same ☐ Worse
2. Has the average severity changed? ☐ Yes ☐ No
   On average, how bad would you rate the headaches (Please choose **ONE**)?
   ☐ Mild ☐ Moderate ☐ Severe
   What is the severity on a scale of 0 to 10 (10 = worst)?
   Mildest: _____ Worst: _____ Average: _____
3. Has the frequency changed? ☐ Yes ☐ No
4. What is the current frequency?
   ☐ <1/month ☐ 1 to 3/month ☐ 1/week ☐ 2 to 3/week ☐ > 3/week ☐ Daily
   ☐ Always ☐ Other _____
5. How many days PER MONTH are you having headaches? _____
6. Are there any warnings that the headache is going to start (auras)? ☐ Yes ☐ No
   ☐ Visual ☐ Auditory ☐ Sensory ☐ Smell ☐ Taste Please explain: _____
7. Does your headache occur on one side of your head [_] and/or both sides [_]?
   On what parts of the head does the headache typically occur?
   ☐ Both Temples/Sides ☐ Left Temple/Side ☐ Right Temple/Side ☐ Front ☐ Top
   ☐ Back ☐ Around Eyes ☐ Behind Eyes ☐ All Over ☐ Other _____
8. What is the headache pain like?
   ☐ Throbbing ☐ Squeezing ☐ Stabbing ☐ Pinching ☐ Pressure ☐ Burning ☐ Sharp
   ☐ Constant ☐ Dull ☐ "There" ☐ Other_____
9. What symptoms are present with the headache?
   ☐ Nausea ☐ Vomiting ☐ Sensitivity to Light ☐ Sensitivity to Sound ☐ Sensitivity to Smells
   ☐ Lightheadedness ☐ Spinning Sensation ☐ Tearing Eyes ☐ Runny Nose ☐ Decrease appetite
   ☐ Stomach Pain ☐ Fatigue ☐ Ringing in the Ears ☐ Changes in Vision
   ☐ Confusion or Difficulty Thinking ☐ Difficulty: Walking/Using Arms/Talking ☐ Other_____
10. Are there any new symptoms with your headaches? ☐ Yes ☐ No Please explain: _____
    _____
11. During a bad headache: *Does your scalp hurt?* ☐ Yes ☐ No *Does your neck hurt?* ☐ Yes ☐ No
    Does your hair hurt? ☐ Yes ☐ No *Do your arms or legs hurt?* ☐ Yes ☐ No
    Does it hurt to do the following: ☐ Comb or Brush Hair ☐ Take a Shower (Hot/Cold) ☐ Wash face
    Does it hurt to wear: ☐ Ponytail ☐ Earrings ☐ Necklace ☐ Hat ☐ Backpack
    ☐ Glasses ☐ Contacts ☐ Headphones ☐ Tight Clothing
    How soon after your headache starts, do these symptoms begin? _____minutes
12. How many MINUTES does it take the headache to reach maximum intensity? _____
13. How many HOURS does the headache last? Shortest: _____ Longest: _____ Average: _____
14. Is there a pattern to the headaches? ☐ Yes ☐ No What pattern? _____

15. Does the headache occur at a particular time of day? ☐ Yes ☐ No
    ☐ Waking up ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ While asleep
16. Are the headaches associated with a particular season? ☐ Yes ☐ No Which season? _____
17. What medication(s) are you taking as needed when your headache occurs? _____
18. Does the medication you take as needed for your headache help? ☐ Yes ☐ No Please explain: _____
    _____
19. Have there been any hospitalizations or ER visits <u>because of headaches</u> since the last visit? ☐ Yes ☐ No
    Date(s)_____
20. How many days of school have you missed because of headaches since the last visit? _____
21. **Does the headache change your activity level (i.e., stop playing)?** ☐ **Yes** ☐ **No**
22. **Does activity or playing make the headache worse?** ☐ **Yes** ☐ **No**
23. **Does the headache hurt more when you walks up stairs?** ☐ **Yes** ☐ **No** ☐ **N/A**
24. **Has your health changed in any way?** ☐ **Yes** ☐ **No**
25. **Are there any other medical problems bothering you now?** ☐ **Yes** ☐ **No** **Please Explain: _____**
    _____

HEADACHE DISABILITY

The following questions try to assess how much the headaches are affecting day-to-day activity. **<u>Your answers should be based on the last three months</u>**. There are no "right" or "wrong" answers so please put down your best guess.

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

1b. How many partial school days were missed in the last 3 months due to headaches (do not include full days counted in the first question)? _____

2. 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)? _____

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

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

5. How many days did you participate in these activities, but functioned at less than half your ability (do not include days counted in question number 4)? _____

Healthy Habits

Drinking: How much water do you drink a day? _____# of 8 oz glasses OR _____ Total ounces
Do you drink caffeine? ☐ Yes ☐ No How many days per week? _____
Are you drinking water in school? _____ With a water bottle? _____ Any problems? _____

Exercise: How many times a week are you exercising?_____

Eating: Are you skipping meals? ☐ Yes ☐ No Which meals? ☐ Breakfast ☐ Lunch ☐ Dinner
How many skipped meals per week? _____ Do you regularly eat vegetables? ☐ Yes ☐ No

Sleeping: How many hours of sleep are you getting a night? _____ Bedtime _____ Wake up time_____
Any difficulty sleeping? ☐ Yes ☐ No Time in minutes to fall asleep _____
Do you get more headaches on a certain day of the week? ☐ Yes ☐ No
Which days? ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

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Menstruation (*for females only*)

Have you had a first menstrual period? ☐ Yes ☐ No ☐ Not Sure ☐ N/A

Are your periods regular? ☐ Yes ☐ No ☐ Not Sure ☐ N/A

Do you notice getting a headache or that some of your headaches are worse with your periods?
☐ Yes ☐ No ☐ Not Sure ☐ N/A

If you haven't had a period OR your periods have just started have you noticed a monthly pattern to your headaches?
☐ Yes ☐ No ☐ Not Sure ☐ N/A

Please help us update your child's medical record.

Has your child been to the ***ER*** or ***Hospitalized*** since last seen? ☐ Yes ☐ No

If so, where and when? _____

What medication(s) is your child taking? _____

_____

REVIEW OF SYSTEMS: Does your child have a history of any of the following?

Constitutional: ☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ Loss of Appetite ☐ Increased Appetite

Pulmonary: ☐ Wheezing ☐ Pneumonia ☐ Shortness of Breath ☐ Frequent Colds ☐ Chronic Cough

***Cardiovascular*:** ☐ Blood pressure ☐ Murmur ☐ Shortness of Breath or Dizziness with Exertion

Gastroenterology Issues: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ G-tube ☐ Obesity ☐ Failure to Thrive

Genitourinary: ☐ Recurrent Urinary Tract Infections ☐ Incontinence

Dermatological: ☐ Skin Rash ☐ Birth Marks

Hematological: ☐ Easy Bruising ☐ Bleeding Tendencies ☐ Nose Bleeds

Sleeping: ☐ Difficulty Staying Asleep ☐ Falling Asleep ☐ Excessive Sleepiness

Endocrine: ☐ Signs of Puberty ☐ Thyroid Problems ☐ Excessive Sweating ☐ Excessive Hunger
☐ Excessive Thirst ☐ Excessive Urination ☐ Always Too Cold ☐ Always Too Hot

Musculoskeletal: ☐ Muscle Pain ☐ Clumsy Walk ☐ Poor Posture

Behavioral: ☐ Depression ☐ Anxiety ☐ Attention ☐ Hyperactivity

Auditory/Vocal: ☐ Hearing or Speech Problems ☐ Recurrent Ear Infections ☐ Problems with Choking or Swallowing

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NEUROLOGICAL:

Has your child recently or is currently experiencing any of these symptoms? (Check all that apply)

- ☐ Change in Behavior
- ☐ Depression or Anxiety
- ☐ Sweating/Tearing
- ☐ Dizziness
- ☐ Neck or Back Pain
- ☐ Changes in Strength or Coordination
- ☐ Unexplained Fever/Weight Loss
- ☐ Swallowing Problems
- ☐ Hearing
- ☐ Sleep Problems
- ☐ Numbness or Tingling
- ☐ Change in School Performance
- ☐ Headache
- ☐ Seizures
- ☐ Tremors
- ☐ Fainting or Passing Out
- ☐ Weakness
- ☐ Changes in Bowel or Bladder Function
- ☐ Change in Appetite
- ☐ Double Vision/Blurred Vision
- ☐ Pain

_____ _____

Signature of Patient/Legally Authorized Representative **Date**

_____ _____

Printed Name of Patient/Legally Authorized Representative **Relationship to Patient**

_____ _____ _____

Practitioner Signature **Date** **Time**

_____

Practitioner Printed Name