Headache Migraine Questionnaire
Pre-Treatment

Name_____ Date:_____

1. When did your migraine headaches start?_____

2. How many migraines do you experience per month on average?_____

3. How many regular headaches do you have per month on average?_____

4. How long do your migraine headaches usually last after you take your medications?
☐ No more than 2 hours ☐ 3-4 hours ☐ 5-12 hours ☐ 12-24 hours ☐ Several days ☐ 1 week or longer

5. How long do your migraine headaches usually last if you do not take your medications?
☐ No more than 2 hours ☐ 3-4 hours ☐ 5-12 hours ☐ 12-24 hours ☐ Several days ☐ 1 week or longer

6. Where is your migraine headaches usually located? (Circle all that apply and indicate which area hurts the most.)

☐ Above/Behind the Eye	Right	Left	Both	☐ Other areas that hurt the most:
☐ Temporal Area	Right	Left	Both	_____
☐ Occipital/ Back of Head	Right	Left	Both	_____

7. How would you describe your migraine headaches?
☐ Throbbing/pounding ☐ Ache/pressure ☐ Ice picks ☐ Dull ☐ Other_____

8. Do your migraine headaches awaken you at night?
☐ Never ☐ Occasionally ☐ Often

9. Do any of the following occur before or during your migraine headaches? (Check all that apply)

☐ Nausea	☐ Vomiting	☐ Diarrhoea	☐ Other
☐ Bothered by light/noise	☐ Blurred/double vision	☐ Sparkling/Flashing/Coloured light	
☐ Eyelid puffy	☐ Eyelid droops	☐ Loss of vision	
☐ Feeling lightheaded	☐ Numbness/tingling	☐ Weakness of arm or leg	
☐ Difficulty concentrating	☐ Speech difficulty	☐ Runny nose	

10. Do any of the following bring on your migraine headaches or make them worse?

☐ Stress (worry, anger)	☐ Bright Sunshine	☐ Weather Changes
☐ Letdown" after stress	☐ Loud Noise	☐ Heavy Lifting
☐ Air Travel	☐ Fatigue	☐ Certain smells or perfume
☐ Missed meals	☐ Sexual Activity	☐ Coughing, straining, bending over
☐ Certain food (Chocolate, cheese, beer, MSG)		☐ Other_____

11. Do any of the following make your migraine headaches better

☐ Rest	☐ Exercise	☐ Quiet and darkness
☐ Hot and Cold compress	☐ Massage	☐ Warm shower
☐ Pressure over migraine headache area		☐ Other_____

12. If you are female, do your migraine headaches change with the following?
☐ Menstrual periods ☐ Birth control pills ☐ Pregnancy ☐ Other

13. Do any of your family members have migraine headaches?
☐ No ☐ Yes, please describe:_____

14. Have you ever had a head or a neck injury requiring medication treatment?
☐ No ☐ Yes, please describe:_____

15. Have you had your migraine headaches evaluated by a neurologist? ☐ No ☐ Yes, if yes, when, where, and by whom?_____

16. What was the diagnosis? ☐ Migraine ☐ Headache ☐ Tension-type ☐ Cluster ☐ Other, specify_____

17. List all the pasts tests you had for your migraine headaches:
☐ MRI Brain/Neck/Both, ☐ MRI/Contrast ☐ CT Scan ☐ EEG ☐ Sleep Study ☐ Other, how long ago?_____

18. List all past treatments for your migraine headaches:
☐ Botox ☐ Nerve Block ☐ IV Meds ☐ Medications

17.a How many treatments did you receive and the dosage?_____

17.b What kind of relief did you get ☐ Complete ☐ Partial ☐ None.

17.c How long did the relief last?_____

19. Have you been treated for a psychiatric condition, if so what condition and when was the last treatment?_____

20. To what extent do your migraine headache affect your quality of life?
☐ Extremely ☐ Moderately ☐ Very Little ☐ Not at all

21. Have you suffered from a head trauma or injury? ☐ No ☐ Yes, if yes state the nature of the injury, when the injury occurred, and treatment provided._____

22. Have you been diagnosed with or had the following treatments within the past year? If so, when/how often?

☐ Eye exam_____ ☐ TMJ_____ ☐ Snore_____ ☐ Wear mouth guard
☐ Wear CPAP_____ ☐ Have Seizures_____ ☐ Wake up w/Migraine_____
☐ Other_____