DALEVILLE COMMUNITY SCHOOLS

Headache Questionnaire

Please return to school nurse

_____ _____ _____

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):

- ☐ throbbing
- ☐ pulsating
- ☐ dull
- ☐ pressure-like
- ☐ aching
- ☐ sharp
- ☐ stabbing
- ☐ electric-like
- ☐ vise-like

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

- ☐ smoke
- ☐ noise
- ☐ exercise
- ☐ stress
- ☐ hunger
- ☐ glare
- ☐ odors
- ☐ food additives
- ☐ bright light
- ☐ lack of sleep
- ☐ too much sleep
- ☐ certain foods
- ☐ change in weather
- ☐ relaxation after stress
- ☐ your periods
- ☐ 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:

- ☐ nausea
- ☐ vomiting
- ☐ dizziness
- ☐ numbness
- ☐ weakness
- ☐ fever
- ☐ neck pain
- ☐ light sensitivity
- ☐ noise sensitivity
- ☐ confusion

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

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

Parent Signature: _____