Cleveland Clinic Canada

Headache Intake Questionnaire

Toronto Health and Wellness Centre
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Tel: 416-507-6600 Fax: 416-507-6610

Headache Education & Prevention Program Questionnaire

Personal Information

Last Name	Given Name(s)

Home Address

City	Prov./State	Postal Code	Primary Phone #	Secondary Phone #

Email	Preferred Contact Method

Emergency Contact	Relationship	Emergency Contact Number:

Where were you born?	Marital Status	Age of children (if applicable)
☐ Canada ☐ Other ______	☐ Single ☐ Married ☐ Common Law ☐ Divorced ☐ Widowed ☐ Separated ☐ Long term relationship ☐ Other ______	

Physicians and Allied Health Professionals

Name	Specialty	Phone	Fax

Current Health Problems (Attach relevant documents and test results if applicable.)	Date of Onset

Past Medical History (Attach relevant documents and test results if applicable.)	Date

Past Surgical History and Injuries (Attach medical documents and test results.)	Date

Medications and Supplements (List all prescription and supplements)

Name	Dosage	Frequency	Date Started

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Do you have any medication allergies? Please list.

Family History

Mother	Father
☐ Alive Age .... ☐ Deceased Cause of death	☐ Alive Age .... ☐ Deceased Cause of death ....
Health Concerns	Health Concerns ....

Siblings

# of Brothers .... **Sisters** .... **Health Concerns** ....

Does anybody in your family have a history of… (List details – who, what age, specific condition, etc.)

Heart Disease (heart attack, stroke, heart failure, high blood pressure, etc.) ....

Neurologic Disease (seizures, brain tumors, epilepsy, etc.) ....

Migraines or other headaches? ....

Work History

Highest level of education			Current occupation	Currently working?
				☐ Yes ☐ On disability ☐ No ☐ Retired
Self employed?	Hours per day?	Hours per week?	Length of time at current employer	Stress level
☐ Yes ☐ No				☐ Low ☐ Medium ☐ High ☐ Extreme

LIFESTYLE HEALTH BEHAVIOURS

How would you rate your health in general? Excellent ◻ Good ◻ Average ◻ Poor ◻

Sleep Questions:	How many hours of sleep do you get each night? ____________________
	Do you have problems falling asleep **Yes** ◻ Problems staying asleep **Yes** ◻ **No** ◻
Eating Behaviours:	Do you eat breakfast each morning? **Yes** ◻ **No** ◻
	Do you eat lunch each day? **Yes** ◻ **No** ◻

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On average, how much caffeine do you consume daily? (*please note the number of drinks/day)*	**Coffee** _____________	**Tea** ______________	**Soft Drinks/cola/pop Coke)**_________
Are you a current smoker?	**No** ☐ **Yes** ☐ If yes, how much do you smoke?	**Are you an ex-smoker?**	**No** ☐ **Yes** ☐ If yes, when did you quit?
Do you use any illicit drugs?	**No** ☐ **Yes** ☐ If yes, which one(s) ____________________ ____________________ ____________________ ____________________	**Have you ever had problems with illicit drugs?**	**No** ☐ **Yes** ☐ If yes, which one(s) ____________________ ____________________ ____________________ ____________________
How much alcohol do you drink on average?	drinks per day ☐ ___ per week ☐ ___ per month ☐ ___	**Have you ever had a problem with alcohol?**	**No** ☐ **Yes** ☐

Stress level at work: Mild ☐ Moderate ☐ High ☐ Very High ☐

Do you manage stress well? Yes ☐ No ☐ Describe ______________________

How do you manage stress? (check all that apply)

- Exercise ☐ Describe ____________________________
- Relaxation techniques ☐ Describe ____________________________
- Hobbies ☐ Describe ____________________________
- Prayer/Spiritual activities ☐ Describe ____________________________
- Family Relationships ☐ Describe ____________________________
- Social Relationships ☐ Describe ____________________________

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HEADACHE-SPECIFIC HISTORY

****** For each question, check all the boxes that apply to you (ie you may check more than 1 box)***

ONSET

1. Did you suffer from headaches when you were younger?

□ As a child　　□ In my 20's – 40's
□ As a teenager　　□ In my 50's or 60's

When were your headaches at their worst? ______________________________

2. When did your current headache problem begin?

Headaches became a problem ____________ Months □ Years □ ago.

3. Precipitating Event - *Was there a precipitating event or trigger for your current headache problem?*

□ None known
□ Specific stress ______________________________
□ Injury ______________________________
□ Motor vehicle accident ______________________________
□ Illness ______________________________
□ Menarche (first period)　　□ Pregnancy
□ Birth Control Pill　　□ Hormone Replacement
□ Other ______________________________

HEADACHE CHARACTERISTICS:

4. Frequency of headaches - *On average, how often do you have headaches?*

They occur __________ times each　□ Day　□ Week　□ Month
Are they increasing in frequency?　□ Yes　□ No
They are more frequent on:
□ Weekdays　□ Weekends
□ Spring　□ Summer　□ Fall　□ Winter

5. Onset of each headache:

Headaches typically begin:　□ Gradually　□ Suddenly　□ Varies
They usually begin in the:　□ Morning　□ Afternoon　□ Evening　□ Night
How long before they reach maximal intensity? _____　□ Minutes　□ Hours

6. Duration of the headaches:

Headaches usually last (with medication) _____　□ Minutes　□ Hours　□ Days
Headaches usually last (without medication) _____　□ Minutes　□ Hours　□ Days

7. Intensity of the headaches - H*ow bad are your headaches*?

With medication:　□ Mild　□ Moderate　□ Severe　□ Incapacitating
Without medication　□ Mild　□ Moderate　□ Severe　□ Incapacitating
Headaches prevent activities　□ School　□ Work　□ Household chores

8. Location of Headaches - *Where do you feel the pain during your headaches*?

□ Left side　□ Right side　□ May be either side　□ Both sides　□ Other ______________
□ Forehead　□ Temple　□ Behind eye(s)　□ Back of head　□ Neck

9. Pain Type - *What does the headache pain feel like?*

□ Pressure　□ Stabbing　□ Throbbing　□ Other ____________________
□ Tight band　□ Burning　□ Dull ache

10. Headache Triggers - *Do any of the following **bring on/trigger** your headaches?*

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- ◻ Foods (specific food triggers will be discussed later in the questionnaire)
- ◻ Too much caffeine ◻ Not getting enough caffeine
- ◻ Hunger / Skipping meals ◻ Alcohol ◻ Wine
- ◻ Fatigue ◻ Too little sleep ◻ Too much sleep (sleeping in)
- ◻ During stressful times ◻ After stress (first day of vacation, weekend, after a test)
- ◻ Menstruation
- ◻ Exercise ◻ Sexual activity ◻ Coughing
- ◻ Prolonged computer work ◻ Weather changes
- ◻ Certain Odors ◻ Bright lights/sun ◻ Loud sounds

Other ____

11. Premonitory Symptoms - *Do you experience any of the following **before** your headache begins?*
- ◻ Mood changes ◻ Personality changes ◻ Other ______________________
- ◻ Change in appetite ◻ Food cravings
- ◻ Neck pain ◻ Fatigue ◻ No, I don't experience any of these

12. Aura Symptoms - *Do you ever experience any of these warning symptoms **before** your headache begins?*
- ◻ Bright lights / flashes of lights/ multi-colored lights (circle applicable description)
- ◻ Zig-zag lines ◻ Partial loss of vision / blurry vision / blindness (circle applicable)
- ◻ Numbness / tingling ◻ Paralysis
- ◻ Dizziness or vertigo ◻ Upset stomach / nausea ◻ No I don't have these

13. Associated Symptoms - *Do you experience any of these symptoms **during** your headaches?*
- ◻ Nausea / upset stomach ◻ Vomiting
- ◻ Bright lights/sun bothers you ◻ Loud sounds bother you
- ◻ Strong smells/odors bother you
- ◻ Dizziness / lightheadedness / vertigo (circle applicable description)
- ◻ Numbness or tingling
- ◻ Increased sensitivity of Scalp / Hair / Ears
- ◻ Eye tears ◻ Runny or stuffy nose
- ◻ Difficulty concentrating ◻ Mood changes / irritability

14. Alleviating Factors - *During a headache, what makes you feel the most comfortable?*
- ◻ Lying down / sleeping ◻ Being in a dark quiet room
- ◻ Keeping physically active ◻ Pacing back-and-forth
- ◻ Massage your head ◻ Tying something around your head
- ◻ Cold pack on your head/neck ◻ Hot pack on your head/neck

HEADACHE-RELATED DISABILITY:

15. Effect of headaches on ability to function:

a) During Milder headaches:
- ◻ I am able to function normally
- ◻ My ability to function is slightly decreased
- ◻ My ability to function is severely decreased
- ◻ I am totally bedridden

b) During moderate or severe headaches:
- ◻ I am able to function normally
- ◻ My ability to function is slightly decreased
- ◻ My ability to function is severely decreased
- ◻ I am totally bedridden

16. Doctor Visits for Headache – *How many times would you estimate that you have visited the following because of your headaches in the past 1 year?*
- ◻ Family physician ______________
- ◻ Walk-in clinic ______________
- ◻ Emergency department ______________

17. How many days of work or school have you missed in the past 1 year because of headaches? __________

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HEADACHE-RELATED INVESTIGATIONS

18. Previous Testing - *Have you had any of the following tests done to investigate your headaches? If yes, please indicate the approximate date and results:*

- ☐ CAT Scan ______________________________
- ☐ MRI ______________________________
- ☐ EEG ______________________________
- ☐ Sinus X-rays ______________ ☐ Neck X-rays ______________
- ☐ Other ______________________________

19. Previous Consultations - *Have you seen any of the following about your headaches? If yes, please give the name, and approximate date:*

- ☐ Neurologist
- ☐ Ear, nose and throat specialist
- ☐ Dentist
- ☐ Psychiatrist
- ☐ Pain Clinic
- ☐ Eye doctor
- ☐ Internal medicine
- ☐ Allergy specialist

____

HEADACHE-SPECIFIC TREATMENT

20. Multi-Disciplinary Health Care - *Have you seen any of the following about your headaches?*

- ☐ Chiropractor
- ☐ Massage therapist
- ☐ Acupuncturist
- ☐ Psychologist
- ☐ Naturopath / homeopath / herbalist
- ☐ Nutritionist
- ☐ Physiotherapist
- ☐ Other ______________________________

21. Headache-Related Purchases - *Have you purchased any of the following to try to treat your headaches?*

- ☐ Hot packs
- ☐ Aromatherapy
- ☐ Herbs / Herbal supplements
- ☐ Cold packs
- ☐ Naturopathic medicines
- ☐ Anti-inflammatory rubs
- ☐ Eye masks
- ☐ Headache self-help book
- ☐ Mouth-guard
- ☐ None of these
- ☐ Other ______________________________

22. Headache Relief from Medications - *How long does it take before you become pain-free after taking your current headache medications?*

☐ Within 1 hour ☐ 1 – 2 hours ☐ > 2 hours ☐ I never become pain-free after medication

23. Current Headache Medications - *Please include all Over-The-Counter and Prescription Medications/Pain Relievers that you are **CURRENTLY** using to **TREAT** your headaches (do not include preventative medication):*

Medication Name & dose	Average & Maximum used in 1 day	How many days used per month	Side-effects	% of time effective
i.e. Tylenol (325 mg)	Average 4; Max 10 tablets	10 days per month	None	
1. …………………….	……………………………….	…………………………	………………	………………
2. …………………….	……………………………….	…………………………	………………	………………
3. …………………….	……………………………….	…………………………	………………	………………
4. …………………….	……………………………….	…………………………	………………	………………
5. …………………….	……………………………….	…………………………	………………	………………
6. …………………….	……………………………….	…………………………	………………	………………

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24. Current Headache Preventative Medications - *Please include all Prescription and Herbal Products that you are* ***CURRENTLY*** *using to* ***PREVENT*** *your headaches:*

	Medication Name	Dose	Side-Effects
1.	………………………………	…………………	…………………………………………………
2.	………………………………	…………………	…………………………………………………
3.	………………………………	…………………	…………………………………………………
4.	………………………………	…………………	…………………………………………………

25. Previously Tried Headache Medications - *Please include all Over-The-Counter and Prescription Medications that you have* ***PREVIOUSLY*** *used to TREAT(not prevent) your headaches but have stopped using:*

	Medication Name	Daily Dosage	Reason for Stopping
1.	……………………	………………	…………………………………………………
2.	……………………	………………	…………………………………………………
3.	……………………	………………	…………………………………………………
4.	……………………	………………	…………………………………………………
5.	……………………	………………	…………………………………………………
6.	……………………	………………	…………………………………………………
7.	……………………	………………	…………………………………………………
8.	……………………	………………	…………………………………………………

(If list exceeds 8, attach an additional paper with a list of all previously used headache pain medications)

26. Previously Tried Headache Preventative Medications - *Please include all Prescription and Herbal Products that you have* ***PREVIOUSLY*** *used to* ***PREVENT*** *your headaches:*

	Medication Name	Daily Dosage	Reason for Stopping
1.	……………………	………………	…………………………………………………
2.	……………………	………………	…………………………………………………
3.	……………………	………………	…………………………………………………
4.	……………………	………………	…………………………………………………
5.	……………………	………………	…………………………………………………
6.	……………………	………………	…………………………………………………
7.	……………………	………………	…………………………………………………
8.	……………………	………………	…………………………………………………

(If list exceeds 8, attach an additional paper with all previously used preventative medications)

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HEADACHE-SPECIFIC QUALITY OF LIFE QUESTIONNAIRE

Please answer each of the following questions by checking the most appropriate answer (1 per question):

1. In the past 4 weeks, how often have headaches interfered with how well you dealt with family, friends and others who are close to you?

   None of the time ☐ **Some of the time** ☐
   Most of the time ☐ **All of the time** ☐

2. In the past 4 weeks, how often have headaches interfered with your leisure time activities, such as reading or exercising?

   None of the time ☐ **Some of the time** ☐
   Most of the time ☐ **All of the time** ☐

3. In the past 4 weeks, how often have you had difficulty performing work or daily activities because of headache symptoms?

   None of the time ☐ **Some of the time** ☐
   Most of the time ☐ **All of the time** ☐

4. In the past 4 weeks, how often did headaches keep you from getting as much done at work or at home as you would like?

   None of the time ☐ **Some of the time** ☐
   Most of the time ☐ **All of the time** ☐

5. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities.

   None of the time ☐ **Some of the time** ☐
   Most of the time ☐ **All of the time** ☐

6. In the past 4 weeks, how often have headaches left you too tired to do work or daily activities?

   None of the time ☐ **Some of the time** ☐
   Most of the time ☐ **All of the time** ☐

7. In the past 4 weeks, how often have headaches limited the number of days you have felt energetic?

   None of the time ☐ **Some of the time** ☐
   Most of the time ☐ **All of the time** ☐

8. In the past 4 weeks, how often have you had to cancel work or daily activities because you had a headache?

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None of the time ☐ **Some of the time** ☐
Most of the time ☐ **All of the time** ☐

9. In the past 4 weeks, how often did you need help in handling routine tasks such as every day household chores, doing necessary business, shopping, or caring for others, when you had a headache?

None of the time ☐ **Some of the time** ☐
Most of the time ☐ **All of the time** ☐

10. In the past 4 weeks, how often did you have to stop work or daily activities to deal with headache symptoms?

None of the time ☐ **Some of the time** ☐
Most of the time ☐ **All of the time** ☐

11. In the past 4 weeks, how often were you not able to go to social activities such as parties or dinner with friends because you had a headache?

None of the time ☐ **Some of the time** ☐
Most of the time ☐ **All of the time** ☐

12. In the past 4 weeks, how often have you felt fed-up or frustrated because of you headaches?

None of the time ☐ **Some of the time** ☐
Most of the time ☐ **All of the time** ☐

13. In the past 4 weeks, how often have you felt like you were a burden on others because of your headaches?

None of the time ☐ **Some of the time** ☐
Most of the time ☐ **All of the time** ☐

14. In the past 4 weeks, how often have you been afraid of letting others down because of your headaches?

None of the time ☐ **Some of the time** ☐
Most of the time ☐ **All of the time** ☐

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HEADACHE MANAGEMENT QUESTIONNAIRE

Please rate each of the following seven questions by circling the most appropriate answer (one per question):

1. The overall effectiveness of treatment you currently use when headache attacks occur.

Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied	Does Not Apply to Me
☐	☐	☐	☐	☐	☐

2. The overall effectiveness of treatment you currently use to prevent headache attacks from occurring.

Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied	Does Not Apply to Me
☐	☐	☐	☐	☐	☐

3. The overall effectiveness of your current treatment on the frequency of your headache symptoms.

Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
☐	☐	☐	☐	☐

4. The overall effectiveness of your current treatment on the severity of your headache symptoms.

Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
☐	☐	☐	☐	☐

5. Your ability to self-manage headache symptoms.

Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
☐	☐	☐	☐	☐

6. Your ability to avoid conditions that may cause headache symptoms to occur.

Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
☐	☐	☐	☐	☐

7. The amount of money you spend on headache symptom treatments.

Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied	Does Not Apply to Me
☐	☐	☐	☐	☐	☐

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HEADACHE DISABILITY QUESTIONNAIRE

Please indicate the number of days over the past 3 months that your headaches affected the activities described in questions 1 to 5 below.	
Questions	**Number of Days**
How many days in the last 3 months did you miss work or school because of your headaches?	
How many days in the last 3 months was your productivity at work or school reduced by headaches?	
How many days in the last 3 months did you not do housework because of your headaches?	
How many days in the last 3 months was your housework productivity reduced by 50% or more because of your headaches?	
How many days in the last 3 months did you miss family, social or leisure activities because of your headaches?	

A. How many days in the last 3 months (90 days) did you have a headache? ______

B. On a scale of 0 to 10 (with 0 = no pain and 10 = pain as bad as it can get), what was the average severity of your headaches over the last 3 months? ______

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Headache-Related Nutrition Questionnaire

1. Are you aware of any specific food triggers that can cause your headaches? Please list:

____
____
____
____

2. If you are aware of food triggers, how did you become aware of your triggers? Please check all that apply, and provide detail if necessary:

- ☐ Observation/instinct ____________________
- ☐ Trial and error ____________________
- ☐ By completing food/symptom diaries ____________________
- ☐ Suggestion from MD, dietician, naturopath ____________________
- ☐ Other (provide details) ____________________

3. Have you made any changes to your eating behaviours to help control your headaches?

- ☐ Strictly avoid specific trigger foods (list foods): ____________________
- ☐ Try to avoid certain trigger foods, but tend to be inconsistent (list): ____________________
- ☐ Reduced my caffeine intake from __________ to __________
- ☐ Changed meal frequency (provide details; how consistently?) ____________________
- ☐ Added breakfast: (yes/no; how frequent?) ____________________
- ☐ Improved my hydration (how much more fluid, what types?): ____________________

4. Please describe your weight:

- ☐ My weight has been fairly stable (within 10 lbs) in my adult life
- ☐ My weight has increased over the years
- ☐ My weight has gradually declined over the years
- ☐ My weight tends to fluctuate up and down

5. Do you diet, follow weight loss programs, or visit weight loss centres (e.g. Weight Watchers, low carb, Bernstein, Fuel for Life, Atkins, etc.)?

- ☐ Never or almost never
- ☐ Yes, I've tried a few diets, diet centres, or programs
- ☐ Frequently. I usually try a few diets or programs each year
- ☐ I'm constantly dieting

6. Do you currently, or have you ever tried supplements (vitamins, minerals, herbs) to help control your headaches? Please list:

SUPPLEMENT	DOSE (IF KNOWN)	LENGTH OF TIME TAKEN	IMPACT

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Physical Activity Questionnaire

Do you engage in regular physical activity? ☐ **Yes** ☐ **No**

Do you have access to a fitness gym? ☐ Yes ☐ No	Do you have a personal trainer/fitness coach? ☐ Yes ☐ No
☐ Commercial ☐ Home ☐ Private studio ☐ Condominium ☐ Work ☐ Other ……………………………………………………………..	Name/contact info (if desired): ………………………………………………………

Equipment/Facilities Available (whether currently used or not):

Cardiovascular	Strength Training	Sports Equipment/Facilities
☐ Treadmill ☐ Stationary Bike ☐ Track ☐ Elliptical ☐ Other: ………………………………………	☐ Free Weights ☐ Machines ☐ Resistance Bands ☐ Physio balls ☐ Other: ………………………………………	☐ Squash/Tennis courts ☐ Golf Course/range ☐ Skiing ☐ Pool ☐ Other: …………………………………..

Current Physical Activities:

Cardiovascular			Strength		
Modes/Type of Training:			**Modes of Training:**		
☐ Treadmill ☐ Stationary Bike ☐ Walking/Jogging	☐ Swimming ☐ Elliptical ☐ Sports (please list): …………………………....		☐ Machines ☐ Free Weights ☐ Other (please list): ………………………………………………….		
How many minutes per day?	☐ 10 to 20 ☐ 20 to 30 ☐ 30 to 40 ☐ 40 to 60 ☐ 60+		**How many minutes per day?**	☐ 10 to 20 ☐ 20 to 30 ☐ 30 to 40 ☐ 40 to 60 ☐ 60 +	
How many times per week?	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ 5 ☐ 6 ☐ 7 ☐ More ………..	**How many times per week?**	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ 5 ☐ 6 ☐ 7 ☐ More ……...
Intensity:	☐ High ☐ Moderate ☐ Low ☐ HR Zones: High ……………. Low ……………. Avg ……………. ☐ Interval Training: Ratio high:low ……………….		**Set Routine:**	☐ Yes ☐ No Sets ………………….….. Reps ………………………. Rest between sets ………….	

Sports You Participate In:

Activity	Yrs Participated	Highest Level of Competition	Current Level of Competition
		☐ Recreational ☐ Competitive ☐ Professional	☐ Recreational ☐ Competitive ☐ Professional
		☐ Recreational ☐ Competitive ☐ Professional	☐ Recreational ☐ Competitive ☐ Professional
		☐ Recreational ☐ Competitive ☐ Professional	☐ Recreational ☐ Competitive ☐ Professional
		☐ Recreational ☐ Competitive ☐ Professional	☐ Recreational ☐ Competitive ☐ Professional

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Psychology Questionnaire – Headache Program

STRESS MANAGEMENT:
Please describe any recent life stressors (e.g. health, relationships, financial, work)?

How do you cope with stress in your life (e.g., physical exercise, meditation, relaxation)?
How helpful are these techniques at managing your current level of stress?

Is it often hard for you to relax and unwind? ☐ **Yes** ☐ **No**

FUNCTIONAL ASSESSMENT:
In the past month have you….

Yes	No	
☐	☐	Had periods of time when you feel down or depressed?
☐	☐	Felt less interested in doing things you normally like to do?
☐	☐	Head periods of excessive energy, mood swings, increased irritability and/or loss of concentration?
☐	☐	Been worrying excessively about a number of things?
☐	☐	Felt very nervous or anxious or suddenly experienced a lot of physical symptoms (e.g., heart racing, sweating)?
☐	☐	Had a fear of losing control of yourself or "going crazy"?
☐	☐	Avoided social situations for fear of what others may think or say about you?
☐	☐	Been afraid of leaving your home alone, or being home alone?
☐	☐	Had repeated thoughts or images in your head that are difficult to dismiss?
☐	☐	Felt compelled to complete certain behaviours repeatedly (e.g., checking to make sure you locked the doors, washing your hands again an etc.)?
☐	☐	Thought a lot about or relived an upsetting event from the past?
☐	☐	Found yourself preoccupied with food, weight or body image?
☐	☐	Been concerned about your use of alcohol or medication/drugs?

Have you been in therapy before or received any prior professional assistance for emotional, psychological relationship issues? ☐ **Yes** ☐ **No** If yes, please describe, starting with most recent/current

Dates	Duration/# of sessions	Physician/Therapist	Type of Therapy/Treatment (marriage counseling, group sessions, etc

Have you ever been diagnosed with a psychological condition (e.g. clinical depression)? ☐ **Yes** ☐ **No**
If yes, please describe.

Thank you for taking the time to complete this form. Your responses will be treated as private and confidential.

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PATIENT OPINIONS/QUESTIONS:

1. What type of headache(s) do you think you have?

2. Do you have any specific concerns/fears about your headaches?

3. What specific questions do you have for Dr. Gladstone and the Headache Program Team?

(a)

(b)

(c)

(d)

(e)

(f)

(g)

Thank-you for taking the time to complete this important questionnaire.

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