PEDIATRIC HEADACHE ASSESSMENT TOOL

CHARACTERISTICS OF HEADACHES
Please check the answers below that describe your headaches:

Would you describe the pain as:
__ Throbbing or pounding
__ Stabbing
__ A dull ache
__ Other Please specify: _____________________________________

Does the pain get better with any of the following?
__ While jumping or playing
__ Coughing or sneezing
__ Staying in a dark room
__ Ice
__ Message
__ Sleep or rest

Does the pain get worse with any of the following?
__ While jumping or playing
__ Coughing or sneezing
__ Staying in a dark room
__ Ice
__ Message
__ Sleep or rest

Please give a number using the scale below:
How much do the headaches usually hurt? ______
Please answer yes or no to the following questions

Does the pain change during the headache? Y/N

If yes: How does it change? _______________

Do you get a headache during?

___School
___Weekends
___Summertime

When do you get a headache?

___In the morning
___In the afternoon
___In the evening
___At nighttime
___No pattern

Please draw where the pain is located
SYMPTOMS

Vision

Do things look different during a headache? Y/N

Do you see any of the following before or during a headache? Please check all that apply

__ Bright or flashing lights
__ Blurred or cloudy vision
__ Seeing 2 of everything
__ Spots
__ Zigzag lines, shapes, or stars
__ Missing parts when looking at objects
__ Complete loss of vision
__ Blind spots
__ Partial blindness or blindness in one side
__ Illuminated or flickering outlines of objects or changing figures

**Nasal Changes**

When you have a headache do you have:
*Please check all that apply*

__A stuffy nose
__A runny nose

**Eye or Facial Changes**

Do you have any of the following changes in your eyes or face?
*Please check all that apply*

__Eyes tear
__Dry eyes
__Redness of the eyes
__Sinus pressure
__Puffy eyes
__Sweat on your forehead or face

**Restlessness or Agitation**

*Please answer yes or no to the following questions:*

Do you feel restless or fidgety when you have a headache?
__Yes ___ No

Do you have to keep moving, rocking, or walking around with a headache?
__Yes ___ No

**Neurological Changes**

When you have a headache do you have any problems with the following:
*Please check all that apply*
__Talking or speaking  
__Thinking  
__Weakness  
___If yes where? ________________
__Tingling or pins or needles  
___If yes where? ________________
__Numbness  
___If yes where? ________________

How long do these symptoms last? ________________

If you had more than one of these symptoms did they:

Please answer yes or no to the following questions:

___Happen together  
___Did one occur before the other  
___Do these symptoms happen with all of your headaches  
___Do these symptoms happen with some of your headaches  

Gastrointestinal Symptoms

Please answer yes or no to the following questions

___Do you ever feel like you are going to throw up during a headache  
___Did you ever throw up with some of the headaches  
___Do you feel like you are going to throw up or throw up WITHOUT a headache  

Sensory Symptoms

Light/Sound

Please answer yes or no to the following questions

___Do lights bother you during a headache
___ Do lights bother you when you don't have a headache
___ Do sounds bother you during a headache
___ Do sounds bother you when you don't have a headache

**Smell**
___ Do smells bother you during a headache
___ Do smells bother you when you don't have a headache

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**Predicting Headaches**

**Triggers**

Do certain things make your headaches begin: YES or NO

If yes: Please list: 
___________________
___________________
___________________
___________________
___________________
___________________

Before your headache starts can you tell it is coming: YES or NO

Before your headache starts do you have any of the following:
Please check all that apply

__ Change in vision
__ Change in speech
__ Trouble thinking
__ Numbness
__ Tingling
__ Weakness
__ Feeling tired
__ Change in mood
__ Change in appetite
__ Feeling like you may throw up
__ Change in sleep pattern
__ Other________ Please explain__________________________
__ Unknown

Timing of Headaches

When do your headaches happen?
Please check all that apply

__ No pattern
__ Morning
__ Afternoon
__ Evening
__ Nighttime
__ Unknown

Duration
Please answer in hours:

How long do your headaches usually last?________________
What is the longest time you ever had a headache? ______________

**Frequency:**
On average how many days in a month do you have a headache? __________
Have your headaches become more frequent? __________
When was your last headache? ______________

**Changes Over Time:**
When was your first headache? ______________
Have the headaches become more or less frequent? __________

Which symptoms if any changed:
Please check all that apply

__Vision Explain ______________
__Thinking Explain ______________
__Light Explain ______________
__Noise Explain ______________
__Smell Explain ______________

Did the length of the headaches increase or decrease? ______________
Did the severity of the headaches increase or decrease? ______________
Did the frequency of the headaches increase or decrease? __________

**Reproductive (Girls Only)**

Please answer yes or no

Have you started your first period? ______________
Are your headaches ever associated with your periods? ______________
Are your headaches ever worse with your periods? ______________
If yes:
__Before
__During
Medications
Which medications have you taken for your headaches?
Current: __________________
_______________________
_______________________
Past: _____________________
_______________________
_______________________

Mood
Please circle the faces below that match how you feel most of the time. This is not when you have a headache.

Please circle the figure that best fits your mood most of the time.
Describe your mood in a few words:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Social

How much have these headaches affected your social life or relationship with friends? Please explain______________________________________________

How many days in the past 3 months were you not able to hang out with your friends because of your headaches? ___________________________________________  

Family_______________________
How much have your headaches affected your relationships with your immediate family members? 
**Please check all that apply**

__Not at all  
__A little  
__Medium  
__A lot  

Explain__________________________________

How many days in a month were you not able to do things at home because of your headaches?

__0 to 3  
__3 to 8  
__8 to 12  
__Over 12  

**School**
How much have your headaches affected your grades in school?

Please check all that apply

__Not at all
__Small decline in grades
__Medium decline in grades
__Large decline in grades

How many full days of school were missed in the last 3 months due to your headaches? ____________________

How many partial days of school were missed in the last 3 months due to your headaches?______________________

How many days in the past 3 months did you function at less than half of your ability because of your headaches? _________________

How many times have you gone to the school nurse because of your headaches in the last 3 months? __________________________