HEADACHE QUESTIONNAIRE

Name:

SSN: Date:

1) When did you start having headaches? (Approximate date)

2) When was your last headache?

3) What causes your headaches?

4) **Describe a typical headache.**

a) Type (for example migraine, sinus, cluster)

b) Location (for example, front, temple, middle, side, back)

c) Symptoms (for example, nausea, vomiting, blurred vision)

5) How often do you get headaches? (for example, daily, weekly, monthly)

6) How long does a typical headache last?

7) Describe any limitations in your activities during a typical headache and how long these limitations last (for example, darkened room, lying without moving, sleep disturbance).

8) List current headache medication(s).

MEDICATION NAME, DOSAGE, AND FREQUENCY	DATE STARTED	IF PRESCRIBED, NAME OF HEALTH CARE PROFESSIONAL	SIDE EFFECT(S)

9) Have you visited an emergency room for treatment to relieve a headache? If so, when and where?

10) Do you use any other treatments to relieve your headaches? If so, describe.

11) If you have seen any health care professionals for your headaches since you filed your claim, complete the chart below.

HEALTH CARE PROFESSIONAL NAME	ADDRESS AND PHONE NUMBER	DATE OF LAST VISIT AND NEXT SCHEDULED APPOINTMENT (IF ANY)

	08-06-2026		
Name of person completing this form (Please print)	Date	Phone	
Address	City	State	Zip Code