New Patient: PEDIATRIC HEADACHE QUESTIONNAIRE

Please complete this questionnaire prior to your appointment. It will be used during the appt & become an part of the medical record. Teens should complete as much as they can independently.

Patient Name___________________ Age___ Date of Birth_________ Today’s Date___________
Address__________________________________________________________________________
Home ph _______________________________ Cell ph ________________________ Work ph ______________________
Pediatrician name __________________________________________________________________

How did you hear about our practice?

☐ Pediatrician referral ☐ Self referral (Internet/Family/Friend) ☐ Other ____________________________

Please bring any and all reports of previous neurological testing, consultation that was done outside the University of Rochester/Golisano Children’s Hospital health system. If the patient has ever had a brain CT, MRI please obtain a copy of the films for the neurologist to review and to add to the medical record.

Please describe why you are bringing your child for evaluation today:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

1. Previous Evaluations

<table>
<thead>
<tr>
<th>Check all that apply</th>
<th>Type of Evaluation</th>
<th>Approx. Date</th>
<th>Provider Name/Location</th>
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<tr>
<td></td>
<td>Neurologist</td>
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<td>Ear/Nose/Throat specialist</td>
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<td>Psychologist/Psychiatrist/Counselor</td>
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<td>Physical Therapy</td>
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<td>Massage</td>
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<td>Acupuncture /Chiropractor</td>
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<td>Relaxation / Biofeedback</td>
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<td>Herbal / Homeopathic medicine</td>
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<td>Other</td>
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2. Previous Testing

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<th>Check all that apply</th>
<th>Test</th>
<th>Date</th>
<th>Result</th>
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<tr>
<td></td>
<td>Important!: Date of last dilated eye exam by Ophthalmologist</td>
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<td>MRI</td>
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<td>MRA / MRV</td>
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<td>Head CT</td>
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<td>Lumbar Puncture</td>
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<td>Sleep Study</td>
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<td>Sinus films</td>
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<td>Other?</td>
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3. **Current Medications:**

<table>
<thead>
<tr>
<th>Medication</th>
<th>For what? (headache, ADHD, asthma, etc)</th>
<th>Pill size (mg) or concentration (mg/ml)</th>
<th>Dose</th>
<th>Times per Day</th>
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4. **Was a diagnosis made for a certain type of headache? (if yes, what type & by who)**

5. **Has the patient been on daily Preventative Headache Medications in the past?** □ NO (if YES, which ones? Please check all that apply) □ Elavil (Amitriptyline) □ Pamela (Nortriptyline) □ Topamax (Topiramate) □ Inderal (Propranolol) □ Periactin (cyproheptadine) □ Depakote (Valproic acid) □ Neurontin (Gabapentine) □ Calan (Verapamil) □ Other ______________________

6. **Abortive Medications:** What medications have been used to treat headache pain? □ None

   □ Advil/Motrin (ibuprofen) □ Tylenol (acetaminophen) □ Aleve/Anaprox (Naproxen) □ Aspirin □ Benadryl (diphenhydramine) □ Compazine (prochlorperazine) □ Zofran (Ondansetron) □ Phenergan (promethazine) □ Indocin (Indomethacin) □ Metrex (sumatriptan) □ Zomig (zolmitriptan) □ Maxalt (Rizatriptan)

   a. **About how many doses of pain reliever medications have you needed to use over the last 4 weeks?** ________________________________________________________________

7. **Vitamins or Supplements:** Have you used nutritional supplements to manage the headaches? □ NO □ Magnesium □ Vitamin B2 (Riboflavin) □ Petadolex (Butterbur) □ Feverfew □ Melatonin □ CoQ10 □ Other ______

8. **Emergency Room Care:** have you ever been treated in a hospital Emergency Room for your headaches? □ No □ Yes (where & when was the last time?) __________________________

9. **Have you ever been hospitalized for headache (overnight)?** □ No □ Yes ____________

10. **Past Medical History**

   a. Any problems during pregnancy/delivery of this child? □ NO □ Yes ________________

   b. **Infancy:** Birth Weight _____ lbs _____ oz Born premature? □ NO □ Yes - How much? _____ wks premature

   c. Were there health problems during infancy? □ NO □ Yes - what kind? ________________________________

   d. List illnesses during childhood for this child ________________________________________________

   e. **Development:** Were there any problems with development? (Not sitting, walking, talking, etc as expected) □ NO □ Yes - what kind? ________________________________

   Was/Is Early Intervention Services involved? □ No □ Yes - circle all that apply: OT / PT / Speech

Any Hospitalizations or Surgeries?

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<tr>
<th>Date</th>
<th>Age</th>
<th>Illness / Surgery</th>
<th>Hospital</th>
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**ROS:** Has this child ever had any of the following problems?

**General health:** □ Missed a significant amount of school due to headaches

**Head:** □ Concussion/Head injury history □ Abnormal head size (too large / too small)

**Eyes:** □ Wears corrective lenses □ Double vision □ Other (describe) ____________

□ Vision changes with headaches (circle all that apply): Blurry - Glare - Flashing lights - Zigzag lines - Tunnel vision

**Other eye conditions:** ________________________________

**Ears / Nose / Throat:** □ Hearing problems □ Recurrent sinus infections □ Recurrent strep throat
Other Psychological Concerns _____________________________________________________________________________________

Skin:  □ Eczema  □ Acne  □ Patches of brown/red/pale skin  □ Significant birthmarks (dark or light patches of skin)
Heart:  □ Murmur  □ Skipped beats/arrhythmias  □ Heart defect  □ High/Low Blood Pressure
Breathing:  □ Asthma  □ Recurrent sinus Infections  □ Snoring  □ Pauses in breathing during sleep
Digestive:  □ Recurrent episodes of nausea/vomiting with headaches  □ Cyclic vomiting  □ Gastric Reflux
Muscles / Bones / Joints:  □ Numbness/tingling w/ headaches  □ Episodes of muscle weakness w/ headache (one-sided or both sides?)
Hormonal / Endocrine / Bleeding:  □ Thyroid problems - Low / High  □ Growing too slow  □ Easy bleeding/bruising  □ Eating disorder
ADOLESCENT GIRLS: Age of onset of menstrual periods ___ yrs  Are periods regular?  □ Yes  □ No
Has the patient ever been on birth control pills or Depo shots?  □ No  □ Yes  Did headaches worsen or improve after beginning these medications?  ______________ Are you on this medicine now?  □ Yes  □ No
Neurologic:  Has the child had any history of the following conditions?
□ Head trauma  □ Brain infections  □ Seizures  □ Staring spells  □ Stroke  □ ADHD
□ Anxiety  □ Depression  □ Motion/Car sickness  □ Learning difficulties  □ Tics
□ Fainting spells  □ Dizziness  □ Fainting spells/Syncope  □ Patches of brown/red/pale skin
□ Low or High muscle tone  □ Autism  □ Tremor  □ Numbness
□ Other neurologic condition/Details regarding any of the above conditions:  ______________________________

Concussion History:  Has your child ever been diagnosed with concussion?  □ NO
□ Yes – How many times?  ____ At what age/s?  ______________
Was there ever loss of consciousness with a concussion injury?  □ NO  □ Yes
We will go over these concussions in detail during the appointment. Please be prepared to supply details of each concussion occurrence, testing & follow up done.

Counseling / Psychiatric:  Has your child ever been seen by a counselor, psychologist or psychiatrist?  □ No
□ Yes – Name of provider  ______________________________
Original concerns:  ______________________________
- Was the experience beneficial?  □ Yes  □ No  ______________
- Is your child still being seen this provider?  □ Yes  □ No

□ Have you, as a parent, or a health care provider ever been concerned about the patient in regards to any of the following symptoms or conditions?
□ Anxiety  □ Worry  □ Depression  □ Suicide ideation
□ Extreme shyness  □ Sleeplessness  □ Obsessive Compulsive  □ Oppositional Defiant Disorder
□ Conduct Disorder  □ Substance abuse  □ Cutting  □ Bipolar  □ ADHD  □ Eating disorder
□ In trouble at School or with the Law
Other psychological concerns  ______________________________
11. Social History & Habits:
a. Who lives in the same house as the patient? If 2 households, list everyone in each household.

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<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to Patient</th>
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b. Is this child adopted? □ No □ Yes – at what age? ______ □ Foster Child
c. Are both parents involved in this child’s daily life? □ Yes □ NO (WHO IS NOT INVOLVED? Mom / Dad )
d. Any of these changes in child’s life (in the last 1-2 yrs)? □ Yes □ Parent separation □ Move
  □ Custody change □ Parent separation □ Move
  □ Parent separation □ Custody change
  □ Parent separation □ Custody change
  □ Parent separation □ Custody change
  □ Parent separation □ Custody change
  □ Parent separation □ Custody change
e. Other stressors at home?

f. Mother’s occupation: ___________________________ Father’s occupation: ___________________________

12. SCHOOL: School Name ____________________________ Current Grade ______

Address ________________________________________________________________

School Nurse ____________________________ Phone Number ____________________________ Fax# ____________________________

Special Services at school (please circle): OT PT Speech Special Ed IEP 504 Plan

Class Size (Please circle): Regular 15:1:1 12:1:1 8:1:1 Homeschooled Other ________________

Has your child had psychoeducational or neuropsychological testing? If yes, when & where?

What was the outcome of the testing?

How many days of school have been missed the most recent school year specifically related to headache?

___ full days missed

___ Part days / In late

___ Sent home ill with headache

Is your child currently participating fully in their usual gym class and sports?

□ Yes □ No → Please explain: ________________________________________________

How have grades been since the headaches began or increased in frequency?

□ Unchanged/Typical for this child □ Worsened □ Improved □ Failing

Most recent grades have been: (circle all that apply) A / B / C / D / F

13. Family Medical History: Please check the box if ANY family members have any of the following conditions and list the person’s relationship to the patient next to the problem.

Migraines ____________________________ ADHD ____________________________

Headaches of any type ____________________________ Tic’s/Tourette’s ____________________________

Motion sickness ____________________________ Syncope/Fainting ____________________________

Seizures ____________________________ Degenerative disease ____________________________

Developmental Delay ____________________________ Mental retardation ____________________________

Learning disabilities ____________________________ Brain Tumors ____________________________

Autism ____________________________ Stroke ____________________________

Early death (before age 35) ____________________________ Bleeding/Clotting disorder ____________________________

Anxiety ____________________________ Depression ____________________________

Bipolar ____________________________ Schizophrenia ____________________________

ODD ____________________________ ODD/Conduct Disorder ____________________________

Form Completed by ____________________________ Relation to patient ____________________________

Date completed ____________________________
**HEADACHE DIARY**

Name__________________________________   Date of Birth ______ / _____ / _____

| Date | Time Headache Began | What was going on when headache began? (in class, sleeping...) | Any Warning Signs that headache was coming on soon? | Part of Head with Pain (forehead, left side...) | Type of Pain (squeezing, throbbing, pressure...) | Intensity of Pain (circle the number that best describes pain: 0=No pain 10= extremely severe) | Other Symptoms (nausea, vomiting, sensitive to light, numbness...) | Treatment (Medication or other things done to lessen the pain or make headache go away) | How did the headache affect usual routine? (went home from school early, stayed in class anyway, missed event...) | Hours of Sleep the Night Before the Headache | Meals missed the day of headache? | Anything exciting or stressful? (Tests, arguments, party...) | How long did the headache last? What helped the most? |
|------|---------------------|---------------------------------------------------------------|----------------------------------------------------|------------------------------------------------|------------------------------------------------|-------------------------------------------------|---------------------------------|--------------------------|-------------------------------------------------|---------------------------------|--------------------------|---------------------------------|---------------------------------|------------------------------------------------|
|      |                     |                                                               |                                                    |                                                 |                                                 |                                                 |                                 |                         |                                                 |                                 |                         |                                 |                                 |                                                 |