Headache History Questionnaire

Please answer every question on the survey if possible. If you are unable to complete the survey all at one time, please make sure you click the button at the bottom of each page "Save and Return Later" so your responses will be saved. Make note of the return code so you can use it later.

Patient Demographics

First and Last name

_____

Date of birth

_____

Address

_____

Phone number

_____

Email address

_____

Health Insurance Company

_____

Health Insurance Policy #

_____

Do you currently have, or are you planning to file, a lawsuit related to your headaches, migraines, or other pain?

- ◯ Yes
- ◯ No

This office does not engage in the practice of providing nor performing evaluations for the purposes of establishing a degree of permanent or partial disability if you are involved in an accident, litigation, or anticipated litigation.

Do you currently have, or are you planning to file, a workers' compensation claim related to your headaches, migraines, or other pain?

- ◯ Yes
- ◯ No

What age were you when your headaches first started?

_____

What provoked your first headache?

- ☐ Injury
- ☐ Menarche (first menstrual period)
- ☐ Pregnancy
- ☐ Other
- ☐ None known

If you selected "injury" or "other," please describe what provoked your first headache.

_____

Please think about your most troublesome headaches when answering all of the following questions.

Current Headache Characteristics:

Location of pain (select all that apply)

- ☐ front of head (frontal)
- ☐ temples (temporal)
- ☐ side of head (parietal)
- ☐ back of head (occipital)
- ☐ around head (holocranial)
- ☐ eye
- ☐ ear
- ☐ jaw
- ☐ neck
- ☐ other

If you selected "other," please describe the location of your pain.

_____

Sidedness (select all that apply)

- ☐ Right-sided
- ☐ Left-sided
- ☐ Both sides
- ☐ Varies
- ☐ Changes sides between attacks
- ☐ Changes sides during attacks
- ☐ Changes sides both between and during attacks

Pain characteristics (select all that apply)

- ☐ throbbing/pulsating
- ☐ achy
- ☐ dull
- ☐ stabbing
- ☐ pressure
- ☐ other

If you selected "other," please describe the characteristics of your head pain.

_____

When your pain throbs, does it feel like it's:

- ◯ inside you skull
- ◯ outside your skull
- ◯ neither of these

How bad is the pain on a scale of 0-100 where 0 is "no pain" and 100 is "the worst pain imaginable"? Use your cursor to slide on the scale.

no pain — moderate pain — the worst pain imaginable

(Place a mark on the scale above)

How disabled are you during or after a headache attack?

- ◯ Engage in normal activity
- ◯ Slight decrease in function
- ◯ Moderate decrease in function
- ◯ Severe decrease in function
- ◯ Confined to bed

If treated with medication, how long do your headaches typically last?	◯ Less than 30 minutes ◯ At least 30 minutes but less than 2 hours ◯ At least 2 hours but less than 4 hours ◯ Between 4 hours and 1 day ◯ Between 1 and 2 days ◯ Between 3 days and 7 days ◯ Longer than 7 straight days
If NOT treated, how long would your headaches typically last?	◯ Less than 30 minutes ◯ At least 30 minutes but less than 2 hours ◯ At least 2 hours but less than 4 hours ◯ Between 4 hours and 1 day ◯ Between 1 and 2 days ◯ Between 3 days and 7 days ◯ Longer than 7 straight days
How many days in the last month did you experience headaches? (This includes all days of head or facial pain whether it be mild, moderate, or severe in intensity).	_____
Based on your answer to the previous question, how many of these days over the past month were your headaches moderate to severe in intensity? (For example, you may have experienced 20 days of headache, of which only 10 were moderate or severe).	_____
Do you ever experience a headache that lasts for 3 or more consecutive days with only brief or no periods of relief?	◯ Yes ◯ No
Do you have a headache every day?	◯ Yes ◯ No
When do you typically get headaches? (select all that apply)	☐ morning ☐ afternoon ☐ evening ☐ night ☐ varies ☐ awakened from sleep by headache ☐ related to menses
Are they more frequent during any of the following times? (select all that apply)	☐ weekends ☐ weekdays ☐ vacation ☐ seasonal ☐ change of the clock/daylight savings time ☐ menses ☐ none of these
If you selected seasonal, which seasons are you more likely to experience headache?	☐ spring ☐ summer ☐ fall ☐ winter

Please think about your most troublesome headaches when answering all of the following questions.

Pre-Headache Symptoms:

Which of the following symptoms do you experience BEFORE the onset of headache? (select all that apply)

- ☐ heightened feeling of wellness
- ☐ hyperactive
- ☐ extremely talkative
- ☐ depressed feeling
- ☐ irritability
- ☐ drowsy
- ☐ restless
- ☐ dizziness
- ☐ difficulty concentrating
- ☐ sensitive to light
- ☐ sensitive to sound/noise
- ☐ sensitive to odors
- ☐ excessive yawning
- ☐ neck stiffness
- ☐ food cravings
- ☐ increased appetite
- ☐ decreased appetite
- ☐ feeling cold
- ☐ diarrhea
- ☐ constipation
- ☐ extremely thirsty
- ☐ increased urination
- ☐ fluid retention
- ☐ other
- ☐ none of these

If you selected "other," what symptoms do you experience before the onset of headache?

_____

Do you experience any of the listed visual symptoms 5-60 minutes before headache pain? (select all that apply)

- ☐ flashing lights
- ☐ zigzag lines
- ☐ loss of vision in one eye
- ☐ loss of vision on one side
- ☐ total blindness
- ☐ tunnel vision
- ☐ none of these

How many minutes do the visual symptoms last?

_____

Do you experience any of these visual symptoms without headache pain?

- ◯ Yes
- ◯ No

Do you experience any of the listed sensory or motor symptoms 5-60 minutes before headache pain? (select all that apply)

- ☐ numbness/tingling
- ☐ vertigo
- ☐ one-sided weakness in face or body
- ☐ speech or language difficulty
- ☐ none of these

How many minutes do these sensory or motor symptoms last?

_____

Do you experience any of these sensory or motor symptoms without headache pain?

- ◯ Yes
- ◯ No

Please think about your most troublesome headaches when answering all of the following questions.

Associated Symptoms:

Which of these symptoms is often associated with your headaches? (select all that apply)

- ☐ nausea
- ☐ vomiting
- ☐ sensitive to light
- ☐ sensitive to sound
- ☐ sensitive to odors
- ☐ diarrhea
- ☐ constipation
- ☐ insomnia
- ☐ scalp tenderness
- ☐ increased urination
- ☐ sore/stiff neck
- ☐ ringing in the ears
- ☐ blurred vision
- ☐ anxiety
- ☐ irritability
- ☐ concentration problems
- ☐ memory problems
- ☐ teeth grinding
- ☐ increased appetite
- ☐ decreased appetite
- ☐ eye tearing
- ☐ nasal congestion
- ☐ eye-redness
- ☐ drooping eyelid
- ☐ change in pupil
- ☐ other
- ☐ none of these

If you answered "other," what symptoms are typically associated with your headache?

_____

Do you experience increased pain or an unpleasant sensation on your skin during your most severe type of headache when you engage in any of the following?

	Never or Rarely	Less than half the time	More than half the time
Combing your hair	○	○	○
Pulling your hair back	○	○	○
Shaving your face	○	○	○
Wearing eyeglasses	○	○	○
Wearing contact lenses	○	○	○
Wearing earrings	○	○	○
Wearing a necklace	○	○	○
Wearing tight clothing	○	○	○
Taking a shower (when water hits your face)	○	○	○
Resting your face or head on a pillow	○	○	○
Exposure to heat (e.g., cooking, washing your face with hot water)	○	○	○
Exposure to cold (e.g., using an ice pack, washing with cold water)	○	○	○

ASC score (present when 3 or more) _____

Please think about your most troublesome headaches when answering all of the following questions.

Headache Factors:

Please select any of the factors that bring on or trigger a headache.

- ☐ fasting or skipped or delayed meals
- ☐ chocolate
- ☐ caffeine
- ☐ nitrates
- ☐ alcoholic beverages (e.g., wine, beer, or liquor)
- ☐ MSG
- ☐ too little fluid intake
- ☐ coughing
- ☐ talking
- ☐ chewing
- ☐ exercise
- ☐ sexual activity
- ☐ menses
- ☐ pregnancy
- ☐ menopause
- ☐ stress
- ☐ environmental allergies
- ☐ weather or temperature changes
- ☐ altitude or air pressure changes
- ☐ sunlight
- ☐ sleep disturbance
- ☐ other triggers
- ☐ none of these

If you selected "other triggers," please list the other triggers for your headaches.

_____

Does your headache make it difficult to do any of the listed activities? (select all that apply)

- ☐ walking
- ☐ climbing steps
- ☐ exercise
- ☐ coughing
- ☐ bending over
- ☐ sneezing
- ☐ sexual activity
- ☐ other activities
- ☐ none of these

If you selected "other activities," which other activities worsen your headache?

_____

Do you use any of the listed relieving factors when you have a headache? (select all that apply)

- ☐ lying down
- ☐ hot compress
- ☐ keeping active/pacing
- ☐ dark quiet room
- ☐ cold compress
- ☐ massage
- ☐ pregnancy
- ☐ sexual activity
- ☐ other factors
- ☐ none of these

If you selected "other factors," what other factors relieve your headache?

_____

Acute Medications

Which of the following NSAIDs, analgesics, or combination medications have you taken in the past?

- ☐ Acetaminophen (Tylenol)
- ☐ Aspirin
- ☐ Excedrin
- ☐ Naproxen (Aleve, Anaprox, Naprosyn)
- ☐ Diclofenac (Cataflam, Voltaren)
- ☐ Ibuprofen (Motrin, Advil)
- ☐ Ketoprofen (Orudis)
- ☐ Ketorolac (Toradol)
- ☐ Flurbiprofen (Ansaid)
- ☐ Indomethacin (Indocin)
- ☐ Celecoxib (Celebrex)
- ☐ Nabumetone (Relafen)
- ☐ Meloxicam (Mobic)
- ☐ Fiorinal
- ☐ Fioricet
- ☐ Darvocet
- ☐ Phrenilin Forte
- ☐ Esgic
- ☐ None of these

Which of the following triptans or ergotamines have you taken in the past?

- ☐ Almotriptan (Axert)
- ☐ Eletriptan (Relpax)
- ☐ Frovatriptan (Frova)
- ☐ Naratriptan (Amerge)
- ☐ Rizatriptan (Maxalt)
- ☐ Sumatriptan (Imitrex)
- ☐ Zolmitriptan (Zomig)
- ☐ Treximet
- ☐ Midrin
- ☐ Onzetra nasal spray
- ☐ Dihydroergotamine (Migranal)
- ☐ Methylergonovine (Methergine)
- ☐ None of these

Which of the following antinausea medications, antihistamines, or other medications have you taken in the past?

- ☐ Metoclopramide (Reglan)
- ☐ Prochlorperazine (Compazine)
- ☐ Ondansetron (Zofran)
- ☐ Meclizine (Antivert/Dramamine)
- ☐ Promethazine (Phenergan)
- ☐ Diphenhydramine (Benadryl)
- ☐ Cyproheptadine (Periactin)
- ☐ Hydroxyzine (Vistaril)
- ☐ Chlorpromazine (Thorazine)
- ☐ None of these

Which of the following steroids, muscle relaxers, or other medications have you taken in the past?

- ☐ Prednisone
- ☐ Dexamethasone (Decadron)
- ☐ Cyclobenzaprine (Flexeril)
- ☐ Baclofen (Lioresal)
- ☐ Tizanidine (Zanaflex)
- ☐ Carisoprodol (Soma)
- ☐ Metaxalone (Skelaxin)
- ☐ Orphenadrine (Norflex)
- ☐ Methocarbamol (Robaxin)
- ☐ Lidocaine nasal spray
- ☐ None of these

Which of the following opioid medications have you taken in the past?

- ☐ Tylenol with Codeine
- ☐ Ultram (Tramadol)
- ☐ Ultracet
- ☐ Butorphanol tartrate (Stadol) nasal spray
- ☐ Percocet
- ☐ Oxycodone or Oxycontin
- ☐ Vicodin/Lortab/Lorcet/Norco
- ☐ Meperidine (Demerol)
- ☐ Morphine
- ☐ Methadone
- ☐ Hydromorphone (Dilaudid)
- ☐ Fentanyl (Duragesic) patch
- ☐ None of these

Prophylactic Medications

Which of the following blood pressure medications have you taken in the past?

- ☐ Propranolol (Inderal)
- ☐ Atenolol (Tenormin)
- ☐ Metoprolol (Lopressor, Toprol)
- ☐ Nadolol (Corgard)
- ☐ Timolol (Blocadren)
- ☐ Verapamil (Calan)
- ☐ Nimodipine (Nimotop)
- ☐ Amlodipine (Norvasc)
- ☐ Flunarizine (Sibelium)
- ☐ Enalapril (Vasotec)
- ☐ Lisinopril (Prinivil-Zestril)
- ☐ Candesartan (Atacand)
- ☐ Olmesartan (Benicar)
- ☐ None of these

Which of the following psychotropic medications have you taken in the past?

- ☐ Amitriptyline (Elavil)
- ☐ Nortriptyline (Pamelor)
- ☐ Doxepin (Sinequan)
- ☐ Imipramine (Tofranil)
- ☐ Protriptyline (Vivactil)
- ☐ Trazodone (Desyrel)
- ☐ Vivactil (Protriptyline)
- ☐ Tranylcypromine (Parnate)
- ☐ Phenelzine (Nardil)
- ☐ Fluoxetine (Prozac)
- ☐ Paroxetine (Paxil)
- ☐ Sertraline (Zoloft)
- ☐ Citalopram (Celexa)
- ☐ Escitalopram (Lexapro)
- ☐ Fluvoxamine (Luvox)
- ☐ Venlafaxine (Effexor)
- ☐ Bupropion (Wellbutrin)
- ☐ Clomipramine (Anafranil)
- ☐ Mirtazapine (Remeron)
- ☐ Duloxetine (Cymbalta)
- ☐ Buspirone (BuSpar)
- ☐ Clonazepam (Klonopin)
- ☐ Diazepam (Valium)
- ☐ Alprazolam (Xanax)
- ☐ Lorazepam (Ativan)
- ☐ Olanzapine (Zyprexa)
- ☐ Quetiapine (Seroquel)
- ☐ Risperidone (Risperdal)
- ☐ Clozapine (Clozaril)
- ☐ Ziprasidone (Geodon)
- ☐ None of these

Which of the following antiseizure medications have you taken in the past?

- ☐ Divalproex (Depakote)
- ☐ Gabapentin (Neurontin)
- ☐ Topiramate (Topamax)
- ☐ Levetiracetam (Keppra)
- ☐ Carbamazepine (Tegretol)
- ☐ Lamotrigine (Lamictal)
- ☐ Oxcarbazepine (Trileptal)
- ☐ Pregabalin (Lyrica)
- ☐ Zonisamide (Zonegran)
- ☐ Phenytoin (Dilantin)
- ☐ None of these

Which of the following neutraceuticals or other medications have you taken in the past	☐ Magnesium ☐ Riboflavin (Vitamin B 2, MigreLief) ☐ Melatonin ☐ Fever Few ☐ Coenzyme Q10 ☐ Petasites/butterbur ☐ Acetazolamide (Diamox) ☐ Memantine (Namenda) ☐ Clonidine (Catapres) ☐ Lithium ☐ None of these
Which of the following injections or procedures have you had in the past to treat your headache?	☐ Botox ☐ Nerve blocks ☐ Trigger point injections ☐ Sphenopalatine ganglion blocks ☐ None of these

Medical History

Sex/Gender	◯ Male ◯ Female ◯ Transgender male ◯ Transgender female ◯ Other sex or gender
Have you spoken with your primary care provider about treatment for your headache?	◯ Yes ◯ No
If so, what treatments have been tried with your PCP? Please also indicate if each of these treatments have been helpful.	_____
Have you been to the Emergency Room or Urgent Care in the past year due to headache?	◯ Yes ◯ No
Please select the tests/scans you have received in the past.	☐ Head MRI ☐ MRA/MRV ☐ Cervical spine MRI ☐ Lumbar spine MRI ☐ Head CT ☐ EEG ☐ Lumbar puncture ☐ EKG ☐ EMG ☐ Sleep Study ☐ None of these
Please provide the date of these tests and their results.	_____
Have you had any of the following medical problems? (select all that apply)	☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke/Transient Ischemic Attack ☐ Seizures/Epilepsy ☐ Head injury ☐ Ear, nose, throat problems ☐ Dental problems ☐ Arthritis ☐ Cervical neck/spine problems ☐ Skin problems ☐ Cancer ☐ Hepatitis/Liver disease ☐ Deep Vein Thrombosis/Phlebitis ☐ Thyroid disease ☐ Pulmonary disease ☐ Asthma ☐ Ulcers/Gastrointestinal problems ☐ Kidney/Renal disease ☐ Infectious disease ☐ Gynecological problems ☐ Psychiatric problems (e.g. depression, anxiety) ☐ Other ☐ None of these

If you selected "other," please list or describe your medical problems.

_____

If you selected psychiatric problems, which of the following psychiatric symptoms have you experienced?

- ☐ Depression
- ☐ Anxiety
- ☐ Posttraumatic Stress Disorder (PTSD)
- ☐ Bipolar disorder
- ☐ Borderline Personality Disorder
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Alcohol or drug problems
- ☐ Eating disorder
- ☐ Schizophrenia

Have you ever been hospitalized or had surgery?

- ◯ Yes
- ◯ No

If so, please describe the reason for hospital stay, the year of the stay, and the name of the hospital.

_____

Are you currently pregnant?

- ◯ Yes
- ◯ No

How many weeks pregnant are you?

_____

How many pregnancies have you had?

_____

Were there any complications with pregnancy?

- ◯ Yes
- ◯ No

At what age did you begin menstruating?

_____

Did you begin having headaches or experience an increase in the severity of your headaches around this age?

- ◯ Yes
- ◯ No
- ◯ Not sure

Are you still menstruating?

- ◯ Yes
- ◯ No

How long is your typical menses?

_____

Does your headache worsen during menses?

- ◯ Yes
- ◯ No

Are you sexually active?

- ◯ Yes
- ◯ No

If so, what is your current method of contraception?

_____

How many hours of sleep per night do you get on average?

_____

Select all that apply.

- ☐ I have no trouble falling asleep
- ☐ I have no trouble staying asleep
- ☐ I have difficulty falling asleep
- ☐ I have difficulty staying asleep
- ☐ I sleep too much
- ☐ I snore
- ☐ I have been diagnosed with sleep apnea
- ☐ My headache awakens me
- ☐ I wake up during the night or early morning for no apparent reason

Social History and Lifestyle

Race	◯ American Indian or Alaska native ◯ Asian ◯ Black or African American ◯ Hispanic or Latino ◯ Native Hawaiian or Other Pacific Islander ◯ White ◯ Other race
Marital status	◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated
Living in:	◯ home ◯ apartment ◯ other
If you selected "other," what type of dwelling do you live in?	_____
How many people are living in your household (including yourself)?	_____
Education:	◯ Some high school ◯ High school graduate or GED ◯ Some college ◯ Associate's degree ◯ Bachelor's degree ◯ Master's degree ◯ Doctorate degree
Employment status (select all that apply)	☐ Part-time ☐ Full-time ☐ Retired ☐ Disabled ☐ Full-time student ☐ Unemployed ☐ Homemaker
What is your occupation?	_____
Do you exercise?	◯ Yes ◯ No
If so, what do you do for exercise and how many times per week do you engage in each activity?	_____
Are you on a special diet?	◯ Yes ◯ No
If so, what kind of special diet do you follow?	_____

Substance Use

Do you currently drink alcohol?	◯ Yes ◯ No
If so, how many alcoholic beverages do you have in an average month?	_____
Have you drank alcohol in the past?	◯ Yes ◯ No
If so, how many alcoholic drinks did you drink per month when your alcohol use was at its highest?	_____
Do you use any of the following drugs? (select all that apply)	☐ marijuana ☐ cocaine/crack ☐ heroin ☐ other ☐ none of the above
If you selected "other," what are the drugs you currently use?	_____
How often do you use this drug (e.g., how many times per day, week, or month)?	_____
Do you currently smoke cigarettes?	◯ Yes ◯ No
If so, how many cigarettes do you smoke per day?	_____
Are you a past smoker?	◯ Yes ◯ No
If so, what year did you quit?	_____
How many caffeinated beverages (e.g., coffee, tea, soda) do you typically drink in 1 week?	_____

Family History

Please select all family members who have been or who were diagnosed with the following conditions.

	Mother	Father	Sibling	Aunt or Uncle	Grandparent
Heart disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Headache (migraine, cluster)	☐	☐	☐	☐	☐
Epilepsy/seizures	☐	☐	☐	☐	☐
Dementia/Alzheimers	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug or alcohol abuse or dependence	☐	☐	☐	☐	☐
Psychiatric diagnosis	☐	☐	☐	☐	☐

Please list ALL medications you are currently taking.

Include over-the-counter medications, herbs, supplements, vitamins, and prescription medication.

Please provide:
1) name of medication
2) dose (mg)
3) number of times you take each medication per day (i.e., 1 pill 2 times per day).

This section is required and must be completed in full before your clinic visit.

Please list your ALLERGIES to medication or environment. If no allergies, write none.

Migraine Treatment Optimization Questionnaire (MTOQ)

Please answer the questions thinking back to the past 4 migraine attacks.

	No, never	Yes, 1/4 times	Yes, half the time	Yes, 3/4 times	Yes, all the time
Are you able to quickly return to your normal activities after taking your migraine medication?	○	○	○	○	○
Can you count on your migraine medication to relieve your pain within 2 hours for most attacks?	○	○	○	○	○
Does one dose of your migraine medication usually relieve your headache and keep it away for at least 24 hours?	○	○	○	○	○
Is your migraine medication well-tolerated?	○	○	○	○	○
Are you comfortable enough to be able to plan your daily activities?	○	○	○	○	○

MTOQ total _____

Migraine Disability Assessment Test

The MIDAS (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. This information is also helpful for your headache specialist to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

1. On how many days in the last 3 months did you miss work or school because of your headaches?	_____
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school)	_____
3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?	_____
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? (Do not include days you counted in question 3 where you did not do household work)	_____
5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?	_____
A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day)	_____
B. On a scale of 0-10, on average how painful were these headaches? (where 0 = no pain at all and 10 = pain as bad as it can be)	_____
MIDAS total	_____

HIT-6

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

		Never	Rarely	Sometimes	Very often	Always
1	When you have headaches, how often is the pain severe?	○	○	○	○	○
2	How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?	○	○	○	○	○
3	When you have a headache, how often do you wish you could lie down?	○	○	○	○	○
4	In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?	○	○	○	○	○
5	In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?	○	○	○	○	○
6	In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?	○	○	○	○	○

HIT-6 Total _____

PHQ-9 and GAD-7

Over the past 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
Worrying too much about different things	○	○	○	○
Having trouble relaxing	○	○	○	○
Being so restless that it is hard to sit still	○	○	○	○
Becoming easily annoyed or irritable	○	○	○	○
Feeling afraid as if something awful might happen	○	○	○	○
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling or staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching TV	○	○	○	○
Moving or speaking so slowly that other people could have noticed. Or the opposite- being so restless that you have been moving around a lot more than usual	○	○	○	○
Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

GAD-7 total _____

PHQ-9 total _____

Additional information

Is English your primary language?	◯ Yes ◯ No
If not, would you like an interpreter to be available for your office visit?	◯ Yes ◯ No
In what language should interpretation be provided?	_____
Are you interested in research that is being conducted at the Hartford HealthCare Headache Center?	◯ Yes ◯ No
Is there a specific research study that you have heard about or are interested in?	_____
How did you hear about the Hartford Healthcare Headache Center?	_____
Full name of referring provider	_____
Please give us any additional information about your headaches that has not already been asked and that you feel is important for us to know. Please keep your response brief.	_____