A division of: AAIC
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Print Last Name: _____

Print First Name: _____

Date of Birth: _____

Appointment Date: _____

QUELL HEADACHE QUESTIONNAIRE

1) Onset

-Age of onset for bothersome headaches: _____

-When did your current headache problem begin? _____ ☐ Months or ☐ Years ago.

-Was there a precipitating event to the current headache problem?

___None

___Specific stress: _____

___Head injury

___Illness

___Menarche (onset of menses)

___Perimenopause/Menopause (start of menopause)

___Birth control pill/hormone replacement

___Pregnancy/Post-partum

___Allergies

___Foods

___Other: _____

2) Headache Characteristics

-Type

-Do you have more than one type of headache? ☐ Yes ☐ No

-If yes, answer these questions regarding your worst headaches, but discuss/describe all headache types during the visit.

-Onset

___ Preceded by “aura” (see next section)

___ “Wake up” headaches (headache already developed upon awakening)

___ Duration to peak intensity < 30 minutes

___ Duration to peak intensity 30-60 minutes

___ Duration to peak intensity > 60 minutes

-Location of pain

___ Unilateral (one side): ☐ Exclusively/always on same side ☐ Can change sides

___ Bilateral (both sides)

___ Can be either unilateral or bilateral

___ Orbital (region around the eye)

___ Frontal (forehead region)

___ Temporal (temple region)

___ Occipital (back of head region)

-Pain description

___ Squeezing or Pressure

___ Throbbing or Pulsating

___ Sharp or Stabbing

___ Other: Describe _____

-Pain intensity

Rate your worst headache pain on a scale from 1 (least severe) to 10 (most severe) ____

-Pain duration

How long can your headaches last if untreated or unsuccessfully treated?

___ < 30 minutes

___ 30 minutes to 3 hours

___ > 4 hours to all day

___ Days

-Frequency

___ 1 day per month or less

___ 1 to 3 days per month

___ 4 to 14 days per month

___ 15+ days per month

___ Multiple headache attacks per day

-Alleviating factors

___ Lying down/rest

___ Dark room

___ Ice pack to head or neck
___ Other: Describe _____

-Aggravating factors
___ Light
___ Noise
___ Movement or physical activity
___ Allergies
___ Other: Describe _____

3) Headache Associated Aura and/or Other Symptoms (please check **all** of your symptoms that occur before, at the time of, or after bothersome headaches)

Gastrointestinal
___ Decreased appetite
___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation

Sensory
___ Scalp Tenderness
___ Tingling
___ Numbness
___ Noise Sensitivity
___ Odor Sensitivity
___ Ringing in Ears

Visual
___ Light Sensitivity
___ Blurry Vision
___ Visual Aura (seeing spots, zigzag lines, blind spots in vision, etc.)
___ Eyelid drooping

Vestibular
___ Dizziness/Unsteadiness
___ Lightheadedness
___ Sensation of Movement (Vertigo)

Mental/Emotional
___ Poor concentration
___ Memory difficulty
___ Confusion
___ Difficulty speaking or saying the right words
___ Restless
___ Mood change

Vasomotor
___ Stuffy Nose
___ Runny Nose
___ Eye Watering
___ Redness of Eye
___ Cold Hands/Feet
___ Pale/Bluish Hands/Feet
___ Flushing

General
___ Fatigue or lack of energy
___ Neck or shoulder pain
___ Food cravings (before headache)
___ Excessive yawning

4) Headache Triggers (please check **all** scenarios that you have identified that seem to trigger headaches)

___ Stress
___ Letdown after stress
___ Weather changes (barometric pressure)
___ Hormonal changes
___ Under sleeping
___ Over sleeping
___ Exercise or exertion
___ Coughing
___ Sexual activity
___ Specific foods
___ Alcohol
___ Dehydration
___ Skipping a meal
___ Bright or flashing

(Menstrual cycle) ___ Medications lights, sunlight
___ Infections (flu, cold, fever, etc.) ___ Too much or too little caffeine ___ Certain odors
___ Allergies (seasonal or perennial) ___ Food(s)

5) Previous Treatment

- **Abortive (Rescue) Treatment**
  - Over The Counter
    - ___ Acetaminophen (Tylenol)
    - ___ NSAIDS (Ibuprofen, Naproxen, Aspirin)
    - ___ Combination analgesics (Excedrin)
  - Prescription
    - Triptans
      - ___ Sumatriptan (Imitrex)
      - ___ Sumatriptan/Naproxen (Treximet)
      - ___ Rizatriptan (Maxalt)
      - ___ Eletriptan (Relpax)
      - ___ Zolmitriptan (Zomig)
      - ___ Naratriptan (Amerge)
      - ___ Frovatriptan (Frova)
    - Dihydroergotamine (DHE)
      - ___ Intravenous DHE (in ER or hospital)
      - ___ DHE Nasal Spray (Migranal)
      - ___ DHE Nasal Spray (Trudhesa)
    - Ditan
      - ___ Lasmiditan (Reyvow)
    - Gepant
      - ___ Ubrogepant (Ubrelvy)
      - ___ Rimegepant (Nurtec)
    - Butalbital
      - ___ Fioricet
      - ___ Fiorinal
    - Opiate Narcotics
      - ___ Hydrocodone, Oxycodone, Tramadol, etc.
- **Preventive Treatment**
  - Blood pressure medication class
    - ___ Propranolol (Inderal)
    - ___ Atenolol (Tenormin)
    - ___ Metoprolol (Toprol)
    - ___ Verapamil (Calan, Verelan, Isoptin)
    - ___ Candesartan (Atacand)

- Antidepressant medication class
  - ___ Amitriptyline (Elavil)
  - ___ Nortriptyline (Pamelor)
  - ___ Venlafaxine (Effexor)
  - ___ Duloxetine (Cymbalta)
  - ___ Other(s): _____
- Anticonvulsant/antiseizure medication class
  - ___ Topiramate (Topamax)
  - ___ Valproic acid (Depakote)
  - ___ Zonisamide (Zonegran)
  - ___ Gabapentin (Neurontin)
- CGRP blocking medication class
  - ___ Atogepant (Qulipta)
  - ___ Rimegepant (Nurtec)
  - ___ Erenumab (Aimovig)
  - ___ Fremanezumab (Ajovy)
  - ___ Galcanezumab (Emgality)
  - ___ Eptinezumab (Vyepti)
- ___ OnabotulinumtoxinA (Botox)

- Other modalities
  - ___ Allergy Testing/Treatments (physician: _____)
  - ___ Sinus Surgery (physician: _____)
  - ___ Sleep/CPAP (physician: _____)
  - ___ Psychotherapy (CBT or other) (therapist: _____)
  - ___ Psychiatry (physician: _____)
    - medication(s): _____
  - ___ Chiropractic Care (chiropractor: _____)
  - ___ Physical Therapy (provider: _____)
  - ___ Acupuncture (provider: _____)

6) Previous Testing

-Imaging (scans)

___ Head CT (CAT scan): Date/Location _____

___ Brain MRI: Date/Location _____

___ Neck (Cervical spine) MRI: Date/Location: _____

___ Other: _____

7) Headache Associated Disability Forms

-Please fill out and bring the attached *Headache Impact Test (HIT-6)* form, the *Migraine Disability Assessment Test (MIDAS)* form, and the *Patient Health Questionnaire-9 (PHQ-9)* form.