

FOREST HEADACHE QUESTIONNAIRE

Answer all questions, yes or no, with a check mark

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Do you have an idea of what may be causing your headache? (Whiplash, diabetes, high blood pressure, eye strain, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	2. Did this same type of headache ever occur before?
<input type="checkbox"/>	<input type="checkbox"/>	3. Do you have more than one type of headache?
<input type="checkbox"/>	<input type="checkbox"/>	4. Is the headache pain so intense that sometimes it becomes unbearable?
<input type="checkbox"/>	<input type="checkbox"/>	5. Do your headaches occur during stressful tension or nervousness at home, at work, or during social occasions?
<input type="checkbox"/>	<input type="checkbox"/>	6. Do your neck, shoulder muscles, or head junction feel tight and painful during the headache?
<input type="checkbox"/>	<input type="checkbox"/>	7. Is your headache pain dull and steady, like an intense constant pressure?
<input type="checkbox"/>	<input type="checkbox"/>	8. Does your headache feel like a tight band around your head?
<input type="checkbox"/>	<input type="checkbox"/>	9. Do you usually have one (1) or more headaches per week?
<input type="checkbox"/>	<input type="checkbox"/>	10. Do your headaches occur during the day?
<input type="checkbox"/>	<input type="checkbox"/>	11. Does mother, father, or any blood relative have similar headaches?
<input type="checkbox"/>	<input type="checkbox"/>	12. Does exertion (lifting, running, straining, sex) affect your headache?
<input type="checkbox"/>	<input type="checkbox"/>	13. Does nausea and/or vomiting occur before or during your headache?
<input type="checkbox"/>	<input type="checkbox"/>	14. Do you have any changes in vision (flashing lights, sensitivity to light, spots, blurred vision, etc.) before or during your headache?
<input type="checkbox"/>	<input type="checkbox"/>	15. Does your headache usually start on one side of the head?
<input type="checkbox"/>	<input type="checkbox"/>	16. Does your headache throb and pulsate or feel like it is pounding?
<input type="checkbox"/>	<input type="checkbox"/>	17. Do your headaches usually occur during the night or upon awakening?
<input type="checkbox"/>	<input type="checkbox"/>	18. Do your headaches usually occur during weekend and holidays?
<input type="checkbox"/>	<input type="checkbox"/>	19. (Females Only) Is your headache associated with your menstrual period?
<input type="checkbox"/>	<input type="checkbox"/>	20. Do you have watering of the eye on the affected side of the headache?
<input type="checkbox"/>	<input type="checkbox"/>	21. Do alcoholic drinks cause or aggravate your headaches?
<input type="checkbox"/>	<input type="checkbox"/>	22. Does chocolate, cheese, milk, nuts, Chinese food, or any other food cause or worsen your headache?
<input type="checkbox"/>	<input type="checkbox"/>	23. Do you have any hearing problems- noise, drainage, or stuffiness in either ear?
<input type="checkbox"/>	<input type="checkbox"/>	24. Have you noticed any paralysis, muscle weakness, numbness, swallowing problems, or speech changes during your headaches?
<input type="checkbox"/>	<input type="checkbox"/>	25. Do you have any facial pain, aching jaws, stuffiness, or congested sinuses along with your headache?
<input type="checkbox"/>	<input type="checkbox"/>	26. Has it been over eighteen (18) months since you last visited a dentist?
<input type="checkbox"/>	<input type="checkbox"/>	27. Have you had tests for headache? (X-Ray, brain scan, injections, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	28. Have you used any previous headache medication? List all medications on the back of this form.