

# PEDIATRIC HEADACHE ASSESSMENT TOOL



## CHARACTERISTICS OF HEADACHES

Please check the answers below that describe your headaches:

Would you describe the pain as:

Throbbing or pounding

Stabbing

A dull ache

Other      Please specify: \_\_\_\_\_

Does the pain get better with any of the following?

While jumping or playing

Coughing or sneezing

Staying in a dark room

Ice

Massage

Sleep or rest

Does the pain get worse with any of the following?

While jumping or playing

Coughing or sneezing

Staying in a dark room

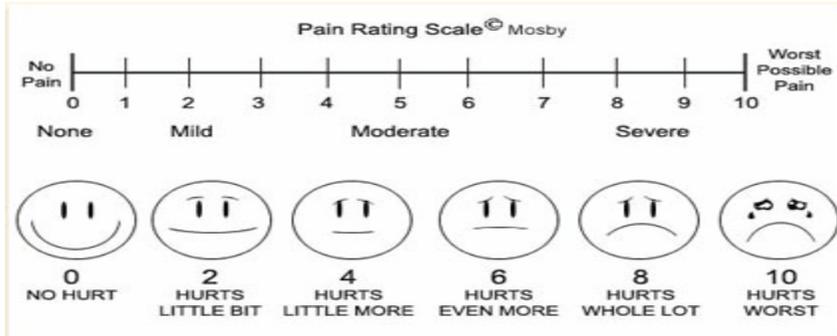
Ice

Massage

Sleep or rest

**Please give a number using the scale below:**

How much do the headaches usually hurt? \_\_\_\_\_



**Please answer yes or no to the following questions**

Does the pain change during the headache? Y/N

If yes: How does it change? \_\_\_\_\_

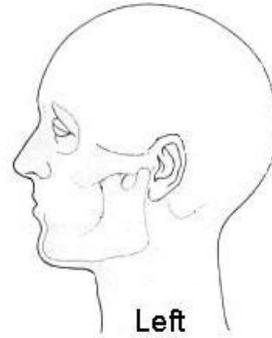
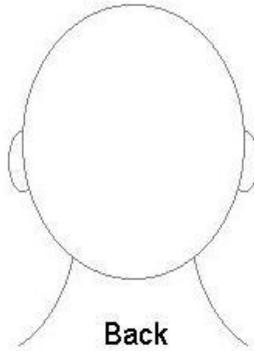
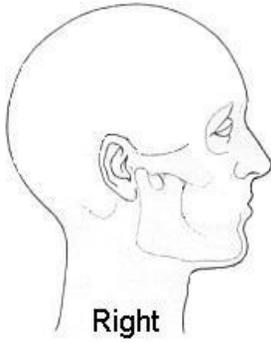
Do you get a headache during?

- School
- Weekends
- Summertime

When do you get a headache?

- In the morning
- In the afternoon
- In the evening
- At nighttime
- No pattern

Please draw where the pain is located



## SYMPTOMS

### Vision



Do things look different during a headache? Y/N

Do you see any of the following before or during a headache?  
**Please check all that apply**

- Bright or flashing lights
- Blurred or cloudy vision
- Seeing 2 of everything
- Spots
- Zigzag lines, shapes, or stars
- Missing parts when looking at objects
- Complete loss of vision
- Blind spots
- Partial blindness or blindness in one side

Illuminated or flickering outlines of objects or changing figures

### **Nasal Changes**

When you have a headache do you have:

**Please check all that apply**

A stuffy nose

A runny nose

### **Eye or Facial Changes**

Do you have any of the following changes in your eyes or face?

**Please check all that apply**

Eyes tear

Dry eyes

Redness of the eyes

Sinus pressure

Puffy eyes

Sweat on your forehead or face

### **Restlessness or Agitation**



**Please answer yes or no to the following questions:**

Do you feel restless or fidgety when you have a headache?

Yes       No

Do you have to keep moving, rocking, or walking around with a headache?

Yes       No

### **Neurological Changes**

When you have a headache do you have any problems with the following:

**Please check all that apply**



- \_\_\_ Do lights bother you when you don't have a headache
- \_\_\_ Do sounds bother you during a headache
- \_\_\_ Do sounds bother you when you don't have a headache

**Smell**

- \_\_\_ Do smells bother you during a headache
- \_\_\_ Do smells bother you when you don't have a headache

**Predicting Headaches**

**Triggers**



Do certain things make your headaches begin: YES or NO

If yes: Please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Before your headache starts can you tell it is coming: YES or NO

Before your headache starts do you have any of the following:

**Please check all that apply**

- Change in vision
- Change in speech
- Trouble thinking
- Numbness
- Tingling
- Weakness
- Feeling tired
- Change in mood
- Change in appetite
- Feeling like you may throw up
- Change in sleep pattern
- Other \_\_\_\_\_ Please explain \_\_\_\_\_
- Unknown

**Timing of Headaches**



When do your headaches happen?

**Please check all that apply**

- No pattern
- Morning
- Afternoon
- Evening
- Nighttime
- Unknown

**Duration**

**Please answer in hours:**

How long do your headaches usually last? \_\_\_\_\_

What is the longest time you ever had a headache? \_\_\_\_\_

**Frequency:**

On average how many days in a month do you have a headache? \_\_\_\_\_

Have your headaches become more frequent? \_\_\_\_\_

When was your last headache? \_\_\_\_\_

**Changes Over Time:**

When was your first headache? \_\_\_\_\_

Have the headaches become more or less frequent? \_\_\_\_\_

Which symptoms if any changed:

**Please check all that apply**

Vision Explain \_\_\_\_\_

Thinking Explain \_\_\_\_\_

Light Explain \_\_\_\_\_

Noise Explain \_\_\_\_\_

Smell Explain \_\_\_\_\_

Did the length of the headaches increase or decrease? \_\_\_\_\_

Did the severity of the headaches increase or decrease? \_\_\_\_\_

Did the frequency of the headaches increase or decrease? \_\_\_\_\_

**Reproductive (Girls Only)**



**Please answer yes or no**

Have you started your first period? \_\_\_\_\_

Are your headaches ever associated with your periods? \_\_\_\_\_

Are your headaches ever worse with your periods? \_\_\_\_\_

If yes:

Before

During

\_\_After

## **Medications**

Which medications have you taken for your headaches?

Current:

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Past:

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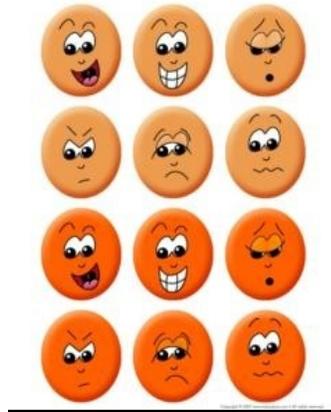
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## **Mood**

Please circle the faces below that match how you feel most of the time. This is not when you have a headache.



Please circle the figure that best fits your mood most of the time.



Describe your mood in a few words:

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## **Social**

How much have these headaches affected your social life or relationship with friends?  
Please explain \_\_\_\_\_

How many days in the past 3 months were you not able to hang out with your friends because of your headaches? \_\_\_\_\_

## **Family**



How much have your headaches affected your relationships with your immediate family members?

**Please check all that apply**

Not at all

A little

Medium

A lot

Explain \_\_\_\_\_

How many days in a month were you not able to do things at home because of your headaches?

0 to 3

3 to 8

8 to 12

Over 12

## **School**



How much have your headaches affected your grades in school?  
**Please check all that apply**

- Not at all
- Small decline in grades
- Medium decline in grades
- Large decline in grades

How many full days of school were missed in the last 3 months due to your headaches? \_\_\_\_\_

How many partial days of school were missed in the last 3 months due to your headaches? \_\_\_\_\_

How many days in the past 3 months did you function at less than half of your ability because of your headaches? \_\_\_\_\_

How many times have you gone to the school nurse because of your headaches in the last 3 months? \_\_\_\_\_