

Patient Full Name _____

Date _____

Instructions: The purpose of this form is to identify difficulties that you may be experiencing because of your headache. Answer each question as it pertains to your headache only.

Please CIRCLE the correct response				
1	I have headache:	1 per month	more than 1 but less than 4 per month	more than 1 per week
2	My headache is:	mild	moderate	severe
Please check (✓) the correct response				
		YES	SOMETIMES	NO
3	Because of my headaches I feel handicapped.			
4	Because of my headaches I feel restricted in performing my routine daily activities.			
5	No one understands the effect my headaches have on my life.			
6	I restrict my recreational activities (e.g., sports, hobbies) because of my headaches.			
7	My headaches make me angry.			
8	Sometimes I feel that I am going to lose control because of my headaches.			
9	Because of my headaches I am less likely to socialize.			
10	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.			
11	My headaches are so bad that I feel that I am going to go insane.			
12	My outlook on the world is affected by my headaches.			
13	I am afraid to go outside when I feel that a headache is starting.			
14	I feel desperate because of my headaches.			
15	I am concerned that I am paying penalties at work or at home because of my headaches.			
16	My headaches place stress on my relationships with family or friends.			
17	I avoid being around people when I have a headache.			
18	I believe my headaches are making it difficult for me to achieve my goals in life.			
19	I am unable to think clearly because of my headaches.			
20	I get tense (e.g., muscle tension) because of my headaches.			
21	I do not enjoy social gatherings because of my headaches.			
22	I feel irritable because of my headaches.			
23	I avoid traveling because of my headaches.			
24	My headaches make me feel confused.			
25	My headaches make me feel frustrated.			
26	I find it difficult to read because of my headaches.			
27	I find it difficult to focus my attention away from my headaches and on other things.			
Column totals:				

For doctor use only: SCORE _____

Scoring: the following responses are given the following values: Yes (4), Sometimes (2), No (0). **Interpretation:** A 29 point change (95% confidence interval) or greater in the total score from test to retest must occur before change can be attributed to treatment effects.