SOMERSET PEDIATRIC GROUP

Name _____ DOB _____ Today's Date _____

Last 24 hours

None = 0 , Mild = 1-2, Moderate = 3-4, Severe = 5-6

Headache	0 1 2 3 4 5 6	Sadness	0 1 2 3 4 5 6
Nausea	0 1 2 3 4 5 6	Irritability	0 1 2 3 4 5 6
Vomiting	0 1 2 3 4 5 6	Nervousness	0 1 2 3 4 5 6
Balance problems	0 1 2 3 4 5 6	Feeling more emotional	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	Numbness or tingling	0 1 2 3 4 5 6
Fatigue	0 1 2 3 4 5 6	Feeling slowed down	0 1 2 3 4 5 6
Trouble falling asleep	0 1 2 3 4 5 6	Feeling mentally foggy	0 1 2 3 4 5 6
Excessive Sleep	0 1 2 3 4 5 6	Difficulty concentrating	0 1 2 3 4 5 6
Loss of Sleep	0 1 2 3 4 5 6	Difficulty remembering	0 1 2 3 4 5 6
Drowsiness	0 1 2 3 4 5 6	Visual problems (eye strain)	0 1 2 3 4 5 6
Sensitivity to light	0 1 2 3 4 5 6	**Total symptom score**:	
Sensitivity to noise	0 1 2 3 4 5 6		

Date of your last headache: _____

Have you had a headache at home, school or with exercise in the **PAST 3 DAYS**? ____ Yes ____ No

If you answered YES, continue filling out this form based on the last 3 days (choose all that apply)

1a. The headache is: ____Always there _____ Come and go

1b. Describe the pain: _____ Pressure _____ Pounding ___ Throbbing

1c. Location on the head: (circle) Lt Front Rt front Rt top Lt top Rt side Lt side Back

1d. On a pain scale from 0 (none) to 10 (go to the ER) what has your headache been? _____

1e. How many headaches do you have a day? _____

1f. How long do your headaches last? _____

2. Do you wake up with a headache? _____Always _____ Sometimes _____ Never

3. Do you get a headache or does your headache worsen with the following activities? If yes, after how many minutes?

Reading _____ Computer _____ Texting _____ TV _____ Video games _____ Car rides_____

What school accommodations would be helpful for you?