Family Wellness Centre of Connecticut

181 Cross Rd, Waterford, CT 06385
860-572-7711
www.fwcct.com

Patient Name_____**Date** _____

Headache Disability Index

PLEASE READ: This questionnaire is designed to enable us to understand how much your headaches have affected your ability to manage your everyday activities. Please answer each section by checking the **ONE CHOICE** that most applies to you. We realize that more than one statement may relate to you, but please just check one choice which most closely describes your problem right now.

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week

2. My headache is: (1) mild (2) moderate (3) Severe

3. Answer the following statements with YES, SOMETIMES, or NO.

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

Patient Signature: _____

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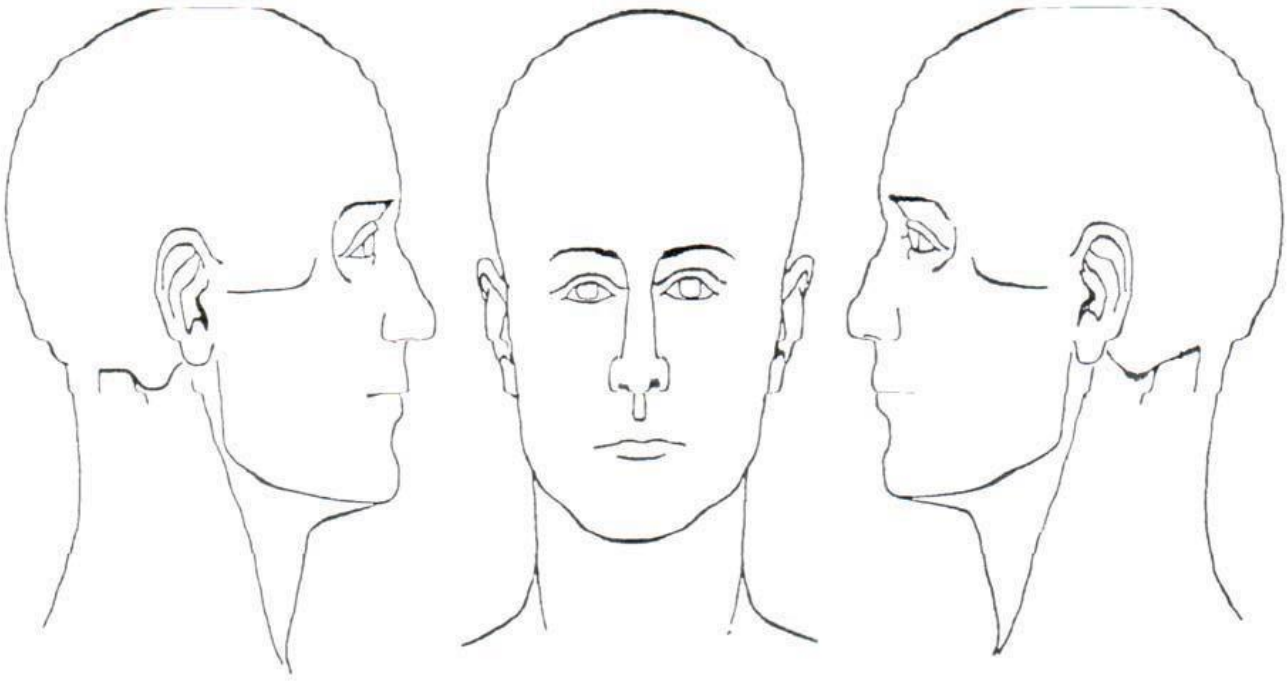
Headache Pain Drawing

Patient Name _____ Date_____

Using the following descriptive symbols, draw the location of your pain on the body outlines below. In addition, mark the level of your pain on the pain scale the bottom of the page.

ACHE	Burning	Numbness	Pins and Needles	Stabbing	Other
VVVVVV	=======	OOOOOO	. . . . .	////////	XXXXXX
VVVVVV	=======	OOOOOO	. . . . .	////////	XXXXXX



Pain Severity Scale:

Rate the severity of your pain by circling one number on the following scale.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Excruciating Pain