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| John R Graham Headache CenterBW/F Department of NeurologyFaulkner Hospital | Date Revised: | 7-13-2009 |
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| SUPPLEMENTAL HEADACHE QUESTIONNAIRE |
| All questions contained in this questionnaire are strictly confidential and will become part of your medical record. |
| Name (Last, First, M.I.): |  |  |
|  **Highest Level of Education (how far in school):** |  |

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| **Depression Screen**For each of the following, please indicate how often you felt that way **during the past week**, using the following ratings *(Total score of* ***4*** *or more is a* ***positive*** *depression screen)*: |
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| **Score**  |
| Rarely or none of the time (less than one day) | 0  |
| Some or a little of the time (1 to 2 days) | 1  |
| Moderately or much of the time (3 to 4 days) | 2  |
| Most or almost all the time (5 to 7 days) | 3  |

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| Item #  | Question  | Score  |
| 1.  | I felt that I could not shake off the blues even with help from my family or friends  | 0   1   2   3  |
| 2.  | I felt depressed  | 0   1   2   3  |
| 3.  | I felt fearful  | 0   1   2   3  |
| 4.  | My sleep was restless  | 0   1   2   3  |

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| **MIDAS QUESTIONNAIRE**INSTRUCTIONS: Please answer the following questions about ALL your headaches you have had over the last three months.  Write your answer in the box next to each question.  Write zero if you did not do the activity in the last 3 months. Please 'tab' through all five boxes to calculate your MIDAS score.

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| **1** | On how many days in the last 3 months did you miss work or school because of your headaches? | days |

|  |  |  |
| --- | --- | --- |
| **2** | How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? *(Do not include days you counted in question 1 where you missed work or school)* | days |

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| --- | --- | --- |
| **3** | On how many days in the last 3 months did you not do household work because of your headaches? | days |

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| --- | --- | --- |
| **4** | How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? *(Do not include days you counted in question 3 where you did not do household work)* | days |

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| --- | --- | --- |
| **5** | On how many days in the last three months did you miss family, social or leisure activities because of your headaches? | days |

|  |  |
| --- | --- |
| **Your rating:**   **TOTAL**:   | days |

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| --- | --- | --- |
| **A** | On how many days in the last 3 months did you have a headache? *(If a headache lasted more than 1 day, count each day)* | days |

|  |  |  |
| --- | --- | --- |
| **B** | On a scale of 0-10, on average how painful were these headaches? *(Where 0 = no pain at all, and 10 = pain as bad as it can be)* |          |

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| --- | --- | --- |
| **Grade** | **Definition** | **Score** |
| I | Minimal or infrequent disability | 0-5 |
| II | Mild or infrequent disability | 6-10 |
| III | Moderate disability | 11-20 |
| IV | Severe disability | 21+ |

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| MIDAS QUESTIONNAIRE |

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### HeaDACHE History

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NAME:

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| --- |
| MENTAL HEALTH |
|  |
| Is stress a major problem for you? | 🞎 | Yes | 🞎 | No |
| Do you feel depressed? | 🞎 | Yes | 🞎 | No |
| Do you have problems with eating or your appetite? | 🞎 | Yes | 🞎 | No |
| Have you ever attempted suicide or seriously thought about hurting yourself? | 🞎 | Yes | 🞎 | No |
| Do you have trouble sleeping? | 🞎 | Yes | 🞎 | No |
| Have you ever been to a counselor? | 🞎 | Yes | 🞎 | No |

**CAGE-AID**

1. Have you felt you ought to cut down on your drinking or drug use?

Yes

No

2. Have people annoyed you by criticizing your drinking or drug use?

Yes

No

3. Have you felt bad or guilty about your drinking or drug use?

Yes

No

4. Have you ever had a drink or used drugs first thing in the morning to steady

your nerves or to get rid of a hangover (eye-opener)?

Yes

No

Score: \_\_\_\_ /4

Scoring and Interpretation:

Each affirmative answer earns 1 point.

 1 point indicates a possible problem.

 2 points indicate a positive CAGE, further evaluation is indicated.

**OTHER INFORMATION:**