GARDINER FAMILY CHIROPRACTIC
HEADACHE QUESTIONNAIRE (Side 1 of 2)

Name _____ Date _____

The purpose of this questionnaire is to measure your perceived disability from your headaches. The selections you choose will give your doctor information about how your pain has affected your ability to manage in everyday life.

INSTRUCTIONS: In each section, mark with an "X" only *one* box which most closely applies to your *headaches*. *Please answer every section on both sides of this form*.

I HAVE HEADACHES:

- ☐ 1 1 per month
- ☐ 2 More than 1 but less than 4 per month
- ☐ 2 More than one per week

MY HEADACHE IS:

- ☐ 1 Mild
- ☐ 2 Moderate
- ☐ 3 Severe

BECAUSE OF MY HEADACHES I FEEL HANDICAPPED.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

BECAUSE OF MY HEADACHES I FEEL RESTRICTED IN PERFORMING MY ROUTINE DAILY ACTIVITIES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

NO ONE UNDERSTANDS THE EFFECT MY HEADACHES HAVE ON MY LIFE.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I RESTRICT MY RECREATIONAL ACTIVITIES (FOR EXAMPLE – SPORTS, HOBBIES) BECAUSE OF MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

MY HEADACHES MAKE ME ANGRY.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

SOMETIMES I FEEL THAT I AM GOING TO LOSE CONTROL BECAUSE OF MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

BECAUSE OF MY HEADACHES I AM LESS LIKELY TO SOCIALIZE.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

MY SPOUSE (SIGNIFICANT OTHER), OR FAMILY AND FRIENDS HAVE NO IDEA WHAT I AM GOING THROUGH BECAUSE OF MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

MY HEADACHES ARE SO BAD THAT I FEEL THAT I AM GOING TO GO INSANE.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

MY OUTLOOK ON THE WORLD IS AFFECTD BY MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I AM AFRAID TO GO OUTSIDE WHEN I FEEL THAT A HEADACHE IS STARTING.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I FEEL DESPERATE BECAUSE OF MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

GARDINER FAMILY CHIROPRACTIC
HEADACHE QUESTIONNAIRE (Side 2 of 2)

Name _____ Date _____

The purpose of this questionnaire is to measure your perceived disability from your headaches. The selections you choose will give your doctor information about how your pain has affected your ability to manage in everyday life.

INSTRUCTIONS: In each section, mark with an "X" only *one* box which most closely applies to your *headaches*. *Please answer every section on both sides of this form*.

I AM CONCERNED THAT I AM PAYING PENALTIES AT WORK OR AT HOME BECAUSE OF MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

MY HEADACHES PLACE STRESS ON MY RELATIONSHIPS WITH FAMILY OR FRIENDS.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I AVOID BEING AROUND PEOPLE WHEN I HAVE A HEADACHE.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I BELIEVE MY HEADACHES ARE MAKING IT DIFFICULT FOR ME TO ACHIEVE MY GOALS IN LIFE.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I AM UNABLE TO THINK CLEARLY BECAUSE OF MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I GET TENSE (FOR EXAMPLE – MUSCLE TENSION) BECAUSE OF MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I DO NOT ENJOY SOCIAL GATHERINGS BECAUSE OF MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I FEEL IRRITABLE BECAUSE OF MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I AVOID TRAVELING BECAUSE OF MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

MY HEADACHES MAKE ME FEEL CONFUSED.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

MY HEADACHES MAKE ME FEEL FRUSTRATED.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I FIND IT DIFFICULT TO READ BECAUSE OF MY HEADACHES.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes

I FIND IT DIFFICULT TO FOCUS MY ATTENTION AWAY FROM MY HEADACHES AND ONTO OTHER THINGS.

- ☐ 0 No
- ☐ 1 Sometimes
- ☐ 2 Yes