S14r0 Headache Event Form

Ad Hoc Event ID _____

Visit Date (yyyy/mm/dd): _____

Correction:
☐ Yes
☐ No

Screening for Acute Headache:

1. Does your child have a headache now or at any time during the past 7 days?
☐ Yes
☐ No

If YES, answer Items 2-4. If NO, skip to Item 5.

2. Has she/he had similar headaches before?
☐ Yes
☐ No

3. How does your child describe the headache?
☐ Mild, not interfering with activity*
☐ Moderate, interfering with activity somewhat*
☐ SEVERE, UNABLE TO FUNCTION**
☐ Other

3A. Other, describe: _____

4. Did or does your child have a fever or other symptoms with the headache?
☐ Yes
☐ No

4A. If YES, describe other symptoms: _____

Screening for Recurrent Headache:

5. Does your child have recurring headaches?
☐ No
☐ Yes, once in a while (< 1 per month)*
☐ Yes, regularly (1-4 per month)*
☐ Yes, frequently (>/= 1 per week)*

6. Has your child ever had a very severe headache preventing participation in normal activities, or leading to a doctor or emergency room visit?
☐ Yes
☐ No

If parent answered YES to Item 6, complete Items 6A-6D.

6A. Your child is confused or difficult to wake up during headache.
☐ Never
☐ Once in a while*
☐ WITH MOST HEADACHES**

6B. Your child complains of a stiff neck or neck pain during headache.
☐ Never
☐ Once in a while*
☐ WITH MOST HEADACHES**

6C. Your child has a neurological symptom during or after a headache.
☐ Never
☐ Once in a while*
☐ WITH MOST HEADACHES**

6C-1. Became dizzy (as if the room were spinning):
- ☐ Yes
- ☐ No

6C-2. Could not speak or comprehend what was spoken:
- ☐ Yes
- ☐ No

6C-3. Paralysis or inability to move one side of the body or part of the body:
- ☐ Yes
- ☐ No

6C-4. Could not see:
- ☐ Yes
- ☐ No

6C-5. Unsteady gait:
- ☐ Yes
- ☐ No

6C-6. Other:
- ☐ Yes
- ☐ No

6C-6a. Other - specify: _____

6D. Your child is awakened in the middle of the night by a headache which was not present at bed time.
- ☐ Never
- ☐ Once in a while*
- ☐ WITH MOST HEADACHES**

If parent answered NO to Items 5 and 6, skip to Staff I.D. #.

Staff I.D. #: _____