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| **Headache in children - Baseline questionnaire**If there are questions you find difficult to answer, we would like you to choose the most appropriate answer. |

Age

(1) ❑ 7 years

(2) ❑ 8 years

(3) ❑ 9 years

(4) ❑ 10 years

(5) ❑ 11 years

(6) ❑ 12 years

(7) ❑ 13 years

(8) ❑ 14 years

Gender

(1) ❑ Boy

(2) ❑ Girl

How long have you suffered from headache?

(2) ❑ ½ - 1 year

(4) ❑ 1 - 3 years

(3) ❑ More than 3 years

How often do you have a headache?

(1) ❑ 1 - 2 days/week

(2) ❑ 3 - 5 days/week

(3) ❑ Almost every day

How long does your headache last?

(1) ❑ Less than 2 hours

(2) ❑ From 2hrs-1/2 day

(3) ❑ All day

(4) ❑ All day and night

When does the headache most often begin?

(1) ❑ Morning

(5) ❑ Before noon

(2) ❑ Afternoon

(3) ❑ Evening/night

(4) ❑ At different times

Where is your headache most commonly located?

(1) ❑ All over the head

(2) ❑ Backside of the head

(3) ❑ One or both sides of the head

(7) ❑ Forehead

(4) ❑ Behind one eye

(5) ❑ Different locations

Do you have other symptoms with your headache?

|  | Yes | No |
| --- | --- | --- |
| Nausea | (2) ❑ | (1) ❑ |
| Vomiting | (2) ❑ | (1) ❑ |
| Dizziness | (2) ❑ | (1) ❑ |
| Stomach pain | (2) ❑ | (1) ❑ |
| Visual disturbances | (2) ❑ | (1) ❑ |
| Spots in front of eyes | (2) ❑ | (1) ❑ |
| Tingling in arms | (2) ❑ | (1) ❑ |
| Others | (2) ❑ | (1) ❑ |

Does any of these give you a headache?

|  | Yes | No |
| --- | --- | --- |
| Neck pain | (2) ❑ | (1) ❑ |
| Back pain | (2) ❑ | (1) ❑ |
| Stress | (2) ❑ | (1) ❑ |
| Sitting down for long periods | (2) ❑ | (1) ❑ |
| Reading | (2) ❑ | (1) ❑ |
| Sport | (2) ❑ | (1) ❑ |
| Computer/TV | (2) ❑ | (1) ❑ |
| Menstrual period | (2) ❑ | (1) ❑ |

Does any of these relieve your headache?

|  | Yes | No |
| --- | --- | --- |
| Lying down | (2) ❑ | (1) ❑ |
| Sleep | (2) ❑ | (1) ❑ |
| Eat something | (2) ❑ | (1) ❑ |
| Drink something | (2) ❑ | (1) ❑ |
| Go outside for fresh air  | (2) ❑ | (1) ❑ |
| Sport | (2) ❑ | (1) ❑ |
| Medication  | (2) ❑ | (1) ❑ |

Have you had any of these within the last year?

(2) ❑ Neck pain

(1) ❑ Back pain

Do you wear braces on your teeth?

(2) ❑ No

(1) ❑ Yes

How often do you take non-prescription medication for headache?

(5) ❑ Never

(2) ❑ 1 – 3 times/month

(3) ❑ 1 – 3 times/week

(4) ❑ More than 3 times/week

Do you take prescription medication for your headache?

(2) ❑ Yes

(1) ❑ No

What is the name of your prescription medication for headache?

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How often do you take it?

(2) ❑ 1 – 3/month

(3) ❑ 1 – 3/week

(4) ❑ More than 3/week

Do you take medication regularly for other diseased?

(2) ❑ Yes (If yes, for what diseases?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(1) ❑ No

Did you have any of these due to your headache?

|  | Yes | No |
| --- | --- | --- |
| Examination by family doctor | (2) ❑ | (1) ❑ |
| X-rays of your head or neck | (2) ❑ | (1) ❑ |
| MR/CT scan of your head or neck | (2) ❑ | (1) ❑ |
| Blood test | (2) ❑ | (1) ❑ |
| Examination by pediatrician | (2) ❑ | (1) ❑ |

Pick the number on a 0-10 pain scale that describes your most common headache

(1) ❑ 0=no pain

(2) ❑ 1

(3) ❑ 2

(4) ❑ 3

(5) ❑ 4

(6) ❑ 5

(7) ❑ 6

(8) ❑ 7

(9) ❑ 8

(10) ❑ 9

(11) ❑ 10=Worst pain ever, stops your activity

Have you had any previous treatment for your headache?

(2) ❑ No

(1) ❑ Yes

Where have you received treatment for headache?

|  | Yes | No |
| --- | --- | --- |
| Family doctor | (2) ❑ | (1) ❑ |
| Pediatrician | (2) ❑ | (1) ❑ |
| Physiotherapist | (2) ❑ | (1) ❑ |
| Chiropractor | (2) ❑ | (1) ❑ |
| Massage therapist | (2) ❑ | (1) ❑ |
| Reflexologist | (2) ❑ | (1) ❑ |
| Other | (2) ❑ | (1) ❑ |

When was your last treatment for headache?

(1) ❑ Within the last ½ year

(2) ❑ More than ½ year ago

How many times have you hurt your head and/or neck without seeking a doctor or emergency room?

(1) ❑ 0

(2) ❑ 1 - 3

(3) ❑ More than 3

How many times have you hurt your head and/or neck without and been seen by a doctor or gone to the emergency room?

(1) ❑ 0

(2) ❑ 1 - 3

(3) ❑ More than 3

Have you been hospitalized because of an accident to your neck and/or head?

(2) ❑ Yes

(1) ❑ No

Have you ever hurt you head and/or neck in any of these?

|  | Yes | No |
| --- | --- | --- |
| Car accident | (1) ❑ | (2) ❑ |
| Fall of bike | (1) ❑ | (2) ❑ |
| Fallen down more than 2 meters | (1) ❑ | (2) ❑ |
| Fall on trampoline | (1) ❑ | (2) ❑ |
| Fall off horse | (1) ❑ | (2) ❑ |
| Hit by another player in handball/football or other contact sports | (1) ❑ | (2) ❑ |
| Experienced episode of violence to you  | (1) ❑ | (2) ❑ |

Have you had any accidents in sport or playtime, where you had to stay home from school afterwards?

(3) ❑ No

(2) ❑ Yes, one time

(1) ❑ Yes, more than one time

Have you ever had a concussion?

(1) ❑ Yes

(2) ❑ No

How many days off from school do you have on average?

(1) ❑ Less than 5 days/year

(2) ❑ 5 - 20 days/year

(3) ❑ More than 20 days/year

What are the most common reasons for your days off from school?

|  | Yes | No |
| --- | --- | --- |
| Headache | (1) ❑ | (2) ❑ |
| Neck pain | (1) ❑ | (2) ❑ |
| Back pain | (1) ❑ | (2) ❑ |
| Common cold | (1) ❑ | (2) ❑ |
| Earache | (1) ❑ | (2) ❑ |
| Menstruation | (1) ❑ | (2) ❑ |
| Stomach pain | (1) ❑ | (2) ❑ |
| Don’t want to go school | (1) ❑ | (2) ❑ |
| Other reasons | (1) ❑ | (2) ❑ |

Other reasons for days off from school:

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How many days off sick have you had the last year due to headache

(1) ❑ 0

(2) ❑ 1 – 5/year

(3) ❑ 5 – 20/year

(4) ❑ More than 20/year

Does anyone in your family have headaches?

|  | Yes | No |
| --- | --- | --- |
| Mother | (1) ❑ | (2) ❑ |
| Father | (1) ❑ | (2) ❑ |
| Siblings | (1) ❑ | (2) ❑ |

Are you allergic to any of these (you can mark more than one)?

|  | Yes | No |
| --- | --- | --- |
| Pollen | (2) ❑ | (1) ❑ |
| Certain foods | (2) ❑ | (1) ❑ |
| Perfume/soap | (2) ❑ | (1) ❑ |
| Food additives | (2) ❑ | (1) ❑ |
| Certain animals | (2) ❑ | (1) ❑ |
| Dust mites | (2) ❑ | (1) ❑ |
| Smoke | (2) ❑ | (1) ❑ |
| Others | (2) ❑ | (1) ❑ |

Do you have stomach pain?

(4) ❑ Often (more than 1/month)

(3) ❑ Sometimes (6-12/year)

(2) ❑ Rarely (1-5/year)

(1) ❑ No

Does anybody smoke in your home?

(2) ❑ Yes

(1) ❑ No

How do you get to school in the morning?

(1) ❑ Bike

(2) ❑ Walk

(3) ❑ Bus

(4) ❑ By car

(5) ❑ Other

How many hours per week do you do sports?

(1) ❑ 0

(2) ❑ 1 – 3/week

(3) ❑ More than 3/week

What type of sports do you do?

|  | Yes | No |
| --- | --- | --- |
| Ball game | (2) ❑ | (1) ❑ |
| Running | (2) ❑ | (1) ❑ |
| Athletics | (2) ❑ | (1) ❑ |
| Riding | (2) ❑ | (1) ❑ |
| Fitness | (2) ❑ | (1) ❑ |
| Biking | (2) ❑ | (1) ❑ |
| (other) | (2) ❑ | (1) ❑ |

How many hours per day do you spend on computer/TV/iPad/mobile phone?

(1) ❑ 0 - 1 hour/day

(2) ❑ 2 - 4 hours/day

(3) ❑ 5 - 6 hours/day

(4) ❑ More than 6 hours/day

How many hours do you sleep per 24 hours?

(1) ❑ 6 - 8

(2) ❑ 9 - 10

(3) ❑ 11 - 12

Do you sleep well?

(2) ❑ Yes

(1) ❑ No

For girls: Do you have menstruation?

(2) ❑ Yes (at what age did it start? ❑ 8-11 ❑ 12-14)

(3) ❑ No

For girls: Do you take birth control pills?

(2) ❑ No

(1) ❑ Yes

Do you use glasses/contact lenses?

(2) ❑ No

(1) ❑ Yes

|  |
| --- |
| Thank you for your answersYou complete the questionnaire by pressing the ‘Complete’-button. |