# Headache Disability Index

Date_____

Patient Name:_____

**INSTRUCTIONS**: Please **CIRCLE** the correct response:

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

**Please read carefully:** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

| YES | SOMETIMES | NO | |
|---|---|---|---|
| _____ | _____ | _____ | Because of my headaches I feel disabled. |
| _____ | _____ | _____ | Because of my headaches I feel restricted in performing my routine daily activities |
| _____ | _____ | _____ | No one understands the effect my headaches have on my life. |
| _____ | _____ | _____ | I restrict my recreational activities (eg, sports, hobbies) because of my headaches. |
| _____ | _____ | _____ | My headaches make me angry. |
| _____ | _____ | _____ | Sometimes I feel that I am going to lose control because of my headaches. |
| _____ | _____ | _____ | Because of my headaches I am less likely to socialize. |
| _____ | _____ | _____ | My spouse (significant other), or family and friends have no idea what I am going through because of my headaches. |
| _____ | _____ | _____ | My headaches are so bad that I feel that I am going to go insane. |
| _____ | _____ | _____ | My outlook on the world is affected by my headaches. |
| _____ | _____ | _____ | I am afraid to go outside when I feel that a headache is starting. |
| _____ | _____ | _____ | I feel desperate because of my headaches. |
| _____ | _____ | _____ | I am concerned that I am paying penalties at work or at home because of my headaches. |
| _____ | _____ | _____ | My headaches place stress on my relationships with family or friends. |
| _____ | _____ | _____ | I avoid being around people when I have a headache. |
| _____ | _____ | _____ | I believe my headaches are making it difficult for me to achieve my goals in life. |
| _____ | _____ | _____ | I am unable to think clearly because of my headaches. |
| _____ | _____ | _____ | I get tense (eg, muscle tension) because of my headaches |
| _____ | _____ | _____ | I do not enjoy social gatherings because of my headaches. |
| _____ | _____ | _____ | I feel irritable because of my headaches. |
| _____ | _____ | _____ | I avoid traveling because of my headaches. |
| _____ | _____ | _____ | My headaches make me feel confused. |
| _____ | _____ | _____ | My headaches make me feel frustrated. |
| _____ | _____ | _____ | I find it difficult to read because of my headaches. |
| _____ | _____ | _____ | I find it difficult to focus my attention away from my headaches and on other things. |

Instructions: 1. Using this system, if "YES" is checked on any given line, that answer is given 4 points…a "SOMETIMES" answer is given 2 points and a "NO" answer is given zero. 2. Using this system, a score of 10-28% is considered to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

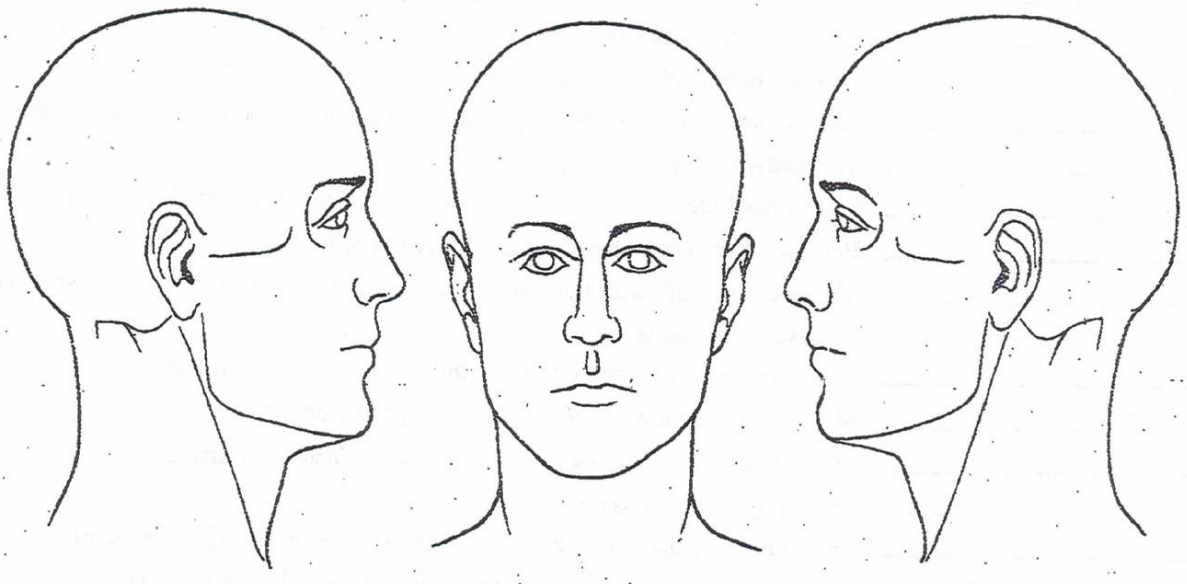
**Patient's Signature:** _____ **Date**: _____

# PAIN DRAWING

Name_____ Date_____

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

| ACHE | BURNING | NUMBNESS | PINS & NEEDLES | STABBING | OTHER |
|---|---|---|---|---|---|
| ^^^^ | ======== | OOOOOOOO | ..... | //////// | XXXX |
| ^^^ | ======= | OOOOOOO | ..... | /////// | XXX |



**PAIN SCALE**

Rate the severity of your pain by checking one box on the following scale.

| No Pain | | | | | | | | | | Worst Possible Pain |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

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