Headache Questionnaire

If you need more space, please attach additional page(s).

Name:

Case ID:	SSA Bar Code

1) When did you start having headaches? (Approximate date)

2) What is the date of your last headache?

3) What causes your headaches?

4) Describe a typical headache:

a) Type (for example, migraine, sinus, cluster)

b) Location (for example, front, temple, middle, side, back)

c) Symptoms (for example, nausea, vomiting, blurred vision)

5) How often do you get headaches? (for example, daily, weekly, monthly)

6) How long does a typical headache last?

7) Describe any limitations in your activities during a typical headache and how long these limitations last (for example, darkened room, lying without moving, sleep disturbance).

8) List current headache medication(s).

MEDICATION, DOSAGE, and FREQUENCY	DATE STARTED	IF PRESCRIBED, NAME OF HEALTH CARE PROFESSIONAL	SIDE EFFECT(S)

9) Do you take the medication as prescribed?

☐ Yes ☐ No

If no, explain why:

10) Which of your medications help to alleviate or eliminate your headache symptoms and how long does it take for the medication to take effect?

11) Have you visited an emergency room for treatment to relieve a headache? If so, when and where?

12) Do you use any other treatments to relieve your headaches? If so, describe.

13) List at least two people who have observed at least one of your typical headache events:

Name	Phone
Name	Phone

14) If you have seen any health care professionals for your headaches since you filed your claim, complete the chart below.

HEALTH CARE PROFESSIONAL NAME	ADDRESS AND PHONE NUMBER	DATE OF LAST VISIT AND NEXT SCHEDULED APPOINTMENT (IF ANY)

15) If you listed names and contact information in response to questions 13 and 14, do we have your permission to contact them?

☐ Yes ☐ No

Name of person completing this form (Please print)	Date	Phone

Address

City	State	ZIP Code

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a), and 1631(d) of the Social Security Act, as amended, allow us to collect this information, which we will use to determine benefits eligibility. Providing this information is voluntary, but not providing all or part of the information may prevent an accurate and timely decision on any claim filed. As law permits, we may use and share the information you submit, including with other Federal agencies, private medical and vocational consultants, contractors, and others, as outlined in the routine uses within System of Records Notices 60-0044, 60-0089, and 60-0320, available at www.ssa.gov/privacy. The information you submit may also be used in computer matching programs for Federal benefits eligibility or to recoup debts under these programs.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 45 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to:*** *SSA, 6401 Security Blvd, Baltimore, MD 21235-6401*.