HEADACHE DISABILITY INDEX

Patient Name ____ Date ________________________

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		
_____	______	_____	E1.	Because of my headaches I feel handicapped.
_____	______	_____	F2.	Because of my headaches I feel restricted in performing my routine daily activities.
_____	______	_____	E3.	No one understands the effect my headaches have on my life.
_____	______	_____	F4.	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
_____	______	_____	E5.	My headaches make me angry.
_____	______	_____	E6.	Sometimes I feel that I am going to lose control because of my headaches.
_____	______	_____	F7.	Because of my headaches I am less likely to socialize.
_____	______	_____	E8.	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
_____	______	_____	E9.	My headaches are so bad that I feel that I am going to go insane.
_____	______	_____	E10.	My outlook on the world is affected by my headaches.
_____	______	_____	E11.	I am afraid to go outside when I feel that a headaches is starting.
_____	______	_____	E12.	I feel desperate because of my headaches.
_____	______	_____	F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
_____	______	_____	E14.	My headaches place stress on my relationships with family or friends.
_____	______	_____	F15.	I avoid being around people when I have a headache.
_____	______	_____	F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
_____	______	_____	F17.	I am unable to think clearly because of my headaches.
_____	______	_____	F18.	I get tense (eg, muscle tension) because of my headaches.
_____	______	_____	F19.	I do not enjoy social gatherings because of my headaches.
_____	______	_____	E20.	I feel irritable because of my headaches.
_____	______	_____	F21.	I avoid traveling because of my headaches.
_____	______	_____	E22.	My headaches make me feel confused.
_____	______	_____	E23.	My headaches make me feel frustrated.
_____	______	_____	F24.	I find it difficult to read because of my headaches.
_____	______	_____	F25.	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS:____

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Examiner

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI)*. Neurology 1994;44:837-842.

MODIFIED SOMATIC PERCEPTION QUESTIONNAIRE

Patient Name ____ Date____________________________

Please read carefully:

Please describe how you have felt during the PAST WEEK by checking the closest description of each item.
Mark only one answer to each question.

SYMPTOM	NOT AT ALL	A LITTLE, SLIGHTLY	A GREAT DEAL, QUITE A BIT	EXTREMELY, COULD NOT HAVE BEEN WORSE
1. Heart rate increase				
2. Feeling hot all over				
3. Sweating all over				
4. Sweating in a particular part of the body				
5. Pulse in neck				
6. Pounding in head				
7. Dizziness				
8. Blurred vision				
9. Feeling faint				
10. Everything appearing unreal				
11. Nausea				
12. Butterflies in stomach				
13. Pain or ache in stomach				
14. Stomach churning				
15. Desire to pass water				
16. Mouth becoming dry				
17. Difficulty swallowing				
18. Muscles in neck aching				
19. Legs feeling weak				
20. Muscles twitching or jumping				
21. Tense feeling across forehead				
22. Tense feeling in jaw muscles				

COMMENTS: ____

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EXAMINER: ____

With permission from the publisher, from Main DJ. The modified somatic perception questionnaire. *J Psychosom Res* 1983; 27: 503-514.