

Saponara Brain & Spine Center

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HEADACHE DISABILITY INDEX QUESTIONNAIRE

Patient Name: _____

Date of Test: _____

Please CHECK the correct response:

1. I have headaches: 1 per month more than 1 but less than 4 per month
 more than 1 per week
2. My headache is: mild moderate severe

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

E1. Because of my headaches I feel handicapped.

Yes Sometimes No

F2. Because of my headaches I feel restricted in performing my routine daily activities. Yes Sometimes No

E3. No one understands the effect my headaches have on my life.

Yes Sometimes No

F4. I restrict my recreational activities (eg, sports, hobbies) because of my headaches. Yes Sometimes No

E5. My headaches make me angry.

Yes Sometimes No

- E6. Sometimes I feel that I am going to lose control because of my headaches. **Yes** **Sometimes** **No**
- F7. Because of my headaches I am less likely to socialize.
Yes **Sometimes** **No**
- E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches. **Yes** **Sometimes** **No**
- E9. My headaches are so bad that I feel that I am going to go insane.
Yes **Sometimes** **No**
- E10. My outlook on the world is affected by my headaches.
Yes **Sometimes** **No**
- E11. I am afraid to go outside when I feel that a headache is starting.
Yes **Sometimes** **No**
- E12. I feel desperate because of my headaches.
Yes **Sometimes** **No**
- F13. I am concerned that I am paying penalties at work or at home because of my headaches. **Yes** **Sometimes** **No**
- E14. My headaches place stress on my relationships with family or friends. **Yes** **Sometimes** **No**
- F15. I avoid being around people when I have a headache.
Yes **Sometimes** **No**
- F16. I believe my headaches are making it difficult for me to achieve my goals in life. **Yes** **Sometimes** **No**
- F17. I am unable to think clearly because of my headaches.
Yes **Sometimes** **No**
- F18. I get tense (eg, muscle tension) because of my headaches.
Yes **Sometimes** **No**
- F19. I do not enjoy social gatherings because of my headaches.
Yes **Sometimes** **No**

- E20. I feel irritable because of my headaches.
Yes Sometimes No
- F21. I avoid traveling because of my headaches.
Yes Sometimes No
- E22. My headaches make me feel confused.
Yes Sometimes No
- E23. My headaches make me feel frustrated.
Yes Sometimes No
- F24. I find it difficult to read because of my headaches.
Yes Sometimes No
- F25. I find it difficult to focus my attention away from my headaches and on other things. **Yes Sometimes No**