Name:_____ Date:_____

HEADACHE IMPACT TEST™

Please circle the response that best describes how you feel and calculate the totals below.

1. **When you have headaches, how often is the pain severe?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

2. **How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

3. **When your have a headache, how often do you wish you could lie down?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

4. **In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?**

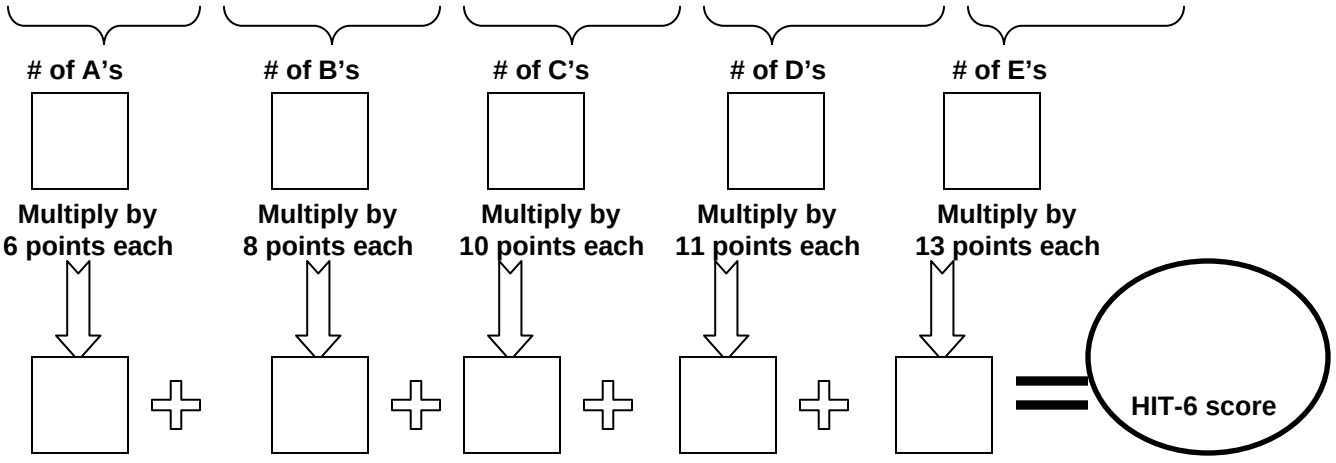
A) Never B) Rarely C) Sometimes D) Very Often E) Always

5. **In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always

6. **In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?**

A) Never B) Rarely C) Sometimes D) Very Often E) Always



Bonus Questions

On a scale of 0-10, with "10" being the worst discomfort imaginable above the shoulders, and a "0" is no pain at all (you feel fabulous), how many mornings per week do you wake with a "0", that is, *you feel fabulous?*_____

On those mornings that you wake "with a number", what's the average number that you have? _____