**Note:** This form is to be completed by trained study personnel, *not* by the participant.

**Traumatic Brain Injury (TBI) History:**

Number of previous TBIs (concussions) not including the TBI (concussion) that led to current post-traumatic headache: \_\_\_\_

*(Example: 0= no prior TBIs; 1= one prior TBI)*

If patient had a history of prior TBIs, did patient suffer PTH in the past (*check one*):  Yes  No

If ‘Yes’, how long ago did you suffer from PTH? \_\_\_ *(Indicate number of days, months or years)*

Days  Months  Years

**TBI that led to current PTH:**

Date of TBI that led to current PTH: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

Date that PTH started: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

How long after TBI did headaches begin

Immediately  Not immediately, but within 24 hours of the TBI  between 24-72 hours

72 hours to 7 days  after 7 days

Did patient have pre-existing headaches?  Yes  No

If yes, how long after TBI did headaches begin to worsen

Immediately  Not immediately, but within 24 hours of the TBI  between 24-72 hours

72 hours to 7 days  after 7 days

**PTH**

Have headaches been continuous (i.e., 24/7) since onset? (*check one*):

Yes  No

*If ‘yes’ is checked, then the headache ratio is automatically 100%. Please skip the headache ratio calculation and move to the section “For all patients with PTH to complete”.*

**For patients who have had PTH for fewer than 30 days, calculate headache ratio as follows:**

How many days do you have a headache of any duration (minutes or hours) of any kind of severity (mild, moderate or severe)? \_\_\_ (a)

Number of days passed since onset of PTH: \_\_\_ (b)

\*Headache Ratio calculation (a/b) x100\_\_\_

*Example: If patient describes having 10 headache days since onset of PTH and is being tested on day 20 post onset of PTH then (10/20) x 100 = 50%*

**For patients who have had PTH for at least 30 days:**

Average *monthly* headache frequency of any kind with mild severity: \_\_\_/30

Average *monthly* headache frequency of any kind with moderate severity: \_\_\_/30

Average *monthly* headache frequency of any kind with severe severity: \_\_\_/30

Average days *per month* of complete headache freedom: \_\_\_/30

\*Headache Ratio calculation (average number of days with mild, moderate, severe headache/30 days) x 100 =\_\_\_ % of days with headache.

Headache frequency since TBI (*check one*):

increasing in frequency  decreasing in frequency  stable

Headache intensity since TBI (*check one*):

increasing in intensity  decreasing in intensity  stable

**For patients with less than one month of PTH:**

Headache days per week:

Week 1:  0  1  2  3  4  5  6  7

Week 2:  0  1  2  3  4  5  6  7

Week 3:  0  1  2  3  4  5  6  7

Week 4:  0  1  2  3  4  5  6  7

**For patients with greater than one month to 6 months of PTH:**

Headache days per month (30 days):

Month 1: \_\_\_\_

Month 2: \_\_\_\_

Month 3: \_\_\_\_

Month 4: \_\_\_\_

Month 5: \_\_\_\_

Month 6: \_\_\_\_

**For all patients with PTH to complete:**

How long do headaches last if untreated/inadequately treated?

(*HH:MM*) \_\_\_\_\_\_

Where are the headaches usually located? (*check all that apply*):

Right  Left  Front  Back  Side/Temples Top

What side(s) are the headache(s) usually on? (*check all that apply*)

Right only  Left only  Both sides  Alternating sides

Quality (*check all that apply*):

Pulsating/Throbbing  Pressure/Aching  Stabbing  Burning

Intensity (*check one*):

Mild  Moderate  Severe

Typical headache pain intensity: 0 (no pain) to 10 (most severe pain) scale: \_\_\_\_/10

Maximum headache pain intensity: 0 (no pain) to 10 (most severe pain) scale: \_\_\_\_/10

Current headache pain level: 0 (no pain) to 10 (most severe pain) scale: \_\_\_/10

Headaches worse with physical activity:………………………………………… Yes ……… No

Headaches worse with neck movements:………………………………………… Yes  No

Headaches worse with mental activity (e.g., reading, concentration):…………… Yes  No

Does the individual experience the following symptoms during headache:

Nausea:  Never  Almost never  Sometimes  Often  Almost Always

Vomiting:  Never  Almost never  Sometimes  Often  Almost Always

Sensitivity to light:  Never  Almost never  Sometimes  Often  Almost Always

Sensitivity to sound:  Never  Almost never  Sometimes  Often  Almost Always

Neck Pain/Stiffness:  Never  Almost never  Sometimes  Often  Almost Always

Dizziness and/or vertigo:  Never  Almost never  Sometimes  Often  Almost Always

Gait and/or

postural imbalance:  Never  Almost never  Sometimes  Often  Almost Always

Difficulty with

memory/concentration:  Never  Almost never  Sometimes  Often  Almost Always

|  |  |  |  |
| --- | --- | --- | --- |
| **Headache Symptom** | **Is Symptom Present?** | **If ‘Yes’, is Symptom Unilateral or Bilateral?** | **If ‘Unilateral’, is Symptom Present on Same Side to Headache?** |
| Conjunctival Injection (i.e., white of eye gets red) | Yes  No | Unilateral  Bilateral | Yes  No |
| Tearing | Yes  No | Unilateral  Bilateral | Yes  No |
| Nasal congestion | Yes  No | Unilateral  Bilateral | Yes  No |
| Eyelid swelling | Yes  No | Unilateral  Bilateral | Yes  No |
| Eyelid drooping | Yes  No | Unilateral  Bilateral | Yes  No |
| Miosis (i.e., excessive constriction of the pupil of the eye) | Yes  No | Unilateral  Bilateral | Yes  No |
| Aural fullness (i.e., stuffy ears or fluid in the ears) | Yes  No | Unilateral  Bilateral | Yes  No |
| Facial sweating | Yes  No | Unilateral  Bilateral | Yes  No |

Auras with headaches:  Yes  No

(Please refer to the ICHD3 document for descriptions of the aura type)

Does the individual experience the following aura types with headaches:

Visual:  Never  Almost never  Sometimes  Often  Almost Always

Sensory:  Never  Almost never  Sometimes  Often  Almost Always

Speech and/or language:  Never  Almost never  Sometimes  Often  Almost Always

Motor:  Never  Almost never  Sometimes  Often  Almost Always

Brainstem:  Never  Almost never  Sometimes  Often  Almost Always

Retinal:  Never  Almost never  Sometimes  Often  Almost Always

Other, specify: \_\_\_\_\_\_\_\_\_\_\_  Never  Almost never  Sometimes  Often  Almost Always

Percentage of headaches experienced with auras: \_\_\_\_\_\_%

Does the individual experience the following symptoms on days without headache:

Nausea:  Never  Almost never  Sometimes  Often  Almost Always

Vomiting:  Never  Almost never  Sometimes  Often  Almost Always

Sensitivity to light:  Never  Almost never  Sometimes  Often  Almost Always

Sensitivity to sound:  Never  Almost never  Sometimes  Often  Almost Always

Neck Pain/Stiffness:  Never  Almost never  Sometimes  Often  Almost Always

Dizziness and/or vertigo:  Never  Almost never  Sometimes  Often  Almost Always

Gait and/or

postural imbalance:  Never  Almost never  Sometimes  Often  Almost Always

Difficulty with

memory/concentration:  Never  Almost never  Sometimes  Often  Almost Always

Aura without headache:  Never  Almost never  Sometimes  Often  Almost Always

Post-traumatic headache phenotype (*check all that apply*):

Migraine with aura

Migraine without aura

Chronic migraine

Episodic cluster headache

Chronic cluster headache

Cervicogenic headache

Infrequent episodic tension-type headache

Frequent episodic tension-type headache

Chronic tension-type headache

Other, Specify: \_\_\_\_\_\_\_\_

Headache Family History

Indicate whether the participant or their first-degree blood relatives have a history of the following diagnosis (choose all that apply). Use the relationship to participant codes listed below to complete the table.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Headache Type | Family History of Headache Type? | First Degree  Biological  Relative? | Relationship of  first-degree relative(s) to  participant/subject  (Separate multiple codes  with comma) | Relationship of second-degree relative(s) to participant/subject (Separate multiple codes with comma) |
| Migraine | Yes  No  Unknown | Yes  No | Data to be entered by site. | Data to be entered by site. |
| Post Traumatic  Headache | Yes  No  Unknown | Yes  No | Data to be entered by site. | Data to be entered by site. |
| Other Headache  Type | Yes  No  Unknown | Yes  No | Data to be entered by site. | Data to be entered by site. |

Relationship of Family Member to Participant/Subject Codes

|  |  |
| --- | --- |
| **First-Degree Relatives** | **Second-Degree Relatives** |
| 1 = Biological Mother  2 = Biological Father  3 = Sibling Male  4 = Sibling Female  5 = Non-identical or dizygotic twin Male  6 = Non-identical or dizygotic twin Female  7 = Identical twin Male  8 = Identical twin Female  9 = Full biologic child Male  10 = Full biologic child Female | 11 = Half-Sibling Male  12 = Half-Sibling Female  13 = Maternal Grandmother  14 = Maternal Grandfather  15= Paternal Grandmother  16 = Paternal Grandfather  17 = Maternal Aunt  18 = Maternal Uncle  19 = Paternal Aunt  20 = Paternal Uncle  21 = Grandchild Male  22 = Grandchild Female  23 = Nephew  24 = Niece |

## 

## GENERAL INSTRUCTIONS

This CRF Module is recommended for post-traumatic headache studies. The information provided in this CRF should be completed and reviewed per the study requirements. All data elements included on this CRF Module are classified as Supplemental - Highly Recommended (i.e., essential information for specified conditions, study types, or designs). Please see the Data Dictionary for element classifications.

Please note that this form should be completed by trained study personnel, *not* by the participant.

## SPECIFIC INSTRUCTIONS

Please consider using these additional Case Report Forms for [Headache](https://www.commondataelements.ninds.nih.gov/headache):

* Medical and Family history of Headache/Migraine (History of Disease/Injury Event).
* Headache Calendar (Patient Reported Outcomes).
* Headache Diary-Acute Therapies (Patient Reported Outcomes).
* Headache Diary-Preventive Therapies (Patient Reported Outcomes).
* Migraine Disability Assessment Test (Outcomes and Endpoints/Activities of Daily Living).

Please consider using these additional Case Report Forms for [Traumatic Brain Injury](https://www.commondataelements.ninds.nih.gov/Traumatic%20Brain%20Injury):

* Type, Place, Cause and Mechanism of Injury (History of Disease/Injury Event).
* Neurological Assessment LOC, PTA, and AOC (Physical/Neurological Examination).
* Neurological assessment TBI Symptoms and Signs (Physical/Neurological Examination).
* Definition of Traumatic Brain Injury
* Ohio State University TBI Identification Method (History of Disease/Injury Event).

Please consider using the Allodynia symptom checklist (ASC-12) (Lipton et al., 2008) for assessing headache-related allodynia.

Dysautonomia is a common symptom following TBI. Please consider using questionnaires that assess autonomic function.

REFERENCES

Headache Classification Committee of the International Headache Society (IHS) The International Classification of Headache Disorders, 3rd edition. Cephalalgia. 2018 Jan;38(1):1-211.

Lipton RB, Bigal ME, Ashina S, Burstein R, Silberstein S, Reed ML, Serrano D, Stewart WF; American Migraine Prevalence Prevention Advisory Group. Cutaneous allodynia in the migraine population. Ann Neurol. 2008 Feb;63(2):148-58.