## Note: Questions in the module are for migraine history and not related to timeline of concussion.

## MIGRAINE QUESTIONNAIRE

## Have you had one or more headaches in the past 3 months (unrelated to concussion timeline), unrelated to alcohol/substance use? Yes No

## MIGRAINE ASSESSMENT TOOL

## Did headaches start within 2 weeks of concussion? Yes No

## Do you have any brain abnormalities (unrelated to concussion)? Yes No

## Do you have a headache every day? Yes No

## Do you take over-the counter or prescription pain or headache medication more than 4 days per week? Yes No

## Do you have intermittent or constant headache? Intermittent Chronic

## How long does each headache episode last?

## Less than 2 hours Greater than 2 hr

## Do you have neurological symptoms immediately before and/or during your headache?

## Visual scotoma (blind or black spots)

## Visual hallucination (zig zag or wavy lines, colored lights or balls, shimmering patterns)

## Weakness or numbness on one side of body

## Do you have any of these symptoms with headache?

## Pain on one side of head

## Throbbing or pulsing pain sensation

## Pain limits or restricts routine activities

## Pain is made worse by performing routine activities (stair climbing)

## Nausea or vomiting

## Increased sensitivity to normal light

## Increased sensitivity to sound

## Prior treatment for headache? Yes No

## Personal history of migraine headache Yes No

## Any family history of migraine headaches Yes No Unknown

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**Migraine Disability Assessment Scale**

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Instruction:

INSTRUCTIONS: Please answer the following questions about ALL your headaches you have had over the last 3 months. Write your answer in the box next to each question. Write 0 if you did not do the activity in the last 3 months. Please provide numbers; example: everyday headache = 90

1. On how many days in the last 3 months did you miss work or school because of your headaches?

(If you’re not working or going to school, just enter 0.)

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches?

(If you’re not working or going to school, just enter 0.)

*(Do not include days you counted in question 1 where you missed work or school.)*

3. On how many days in the last 3 months did you not do household work because of your headaches?

4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? *(Do not include days you counted in question 3 where you did not do household work.)*

5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

1. On how many days in the last 3 months did you have a headache? *(If a headache lasted more than 1 day, count each day.)*
2. On a scale of 0-10, on average how painful were these headaches? *(Where 0 = no pain at all and 10 = pain as bad as it can be.)*

## General Instructions

Important note: None of the data elements on this CRF Module are considered Core (i.e., strongly recommended for all sports-related concussion clinical studies to collect). They are supplemental and should only be collected if the research team considers them appropriate for their study.

## Specific Instructions

*Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.*