PROVIDENCE ENT

Headache Questionnaire Part II

Patient Name: _____ Date of Birth: _____

Read each sentence carefully. For each statement, check the column that best corresponds to how often you have felt that way during the past two weeks.	Rarely or Never	Occasionally	Frequently	Always
I have difficulty making decisions.				
I have lost interest in aspects of life that used to be important to me.				
I feel fatigued.				
I feel sad, blue and unhappy.				
I am agitated and keep moving around.				
I do things slowly.				
I feel that I am a guilty person who deserves to be punished.				
I spend time thinking about HOW I might kill myself.				
My sleep has been disturbed-too little, too much or broken sleep.				
I feel lifeless-more dead than alive.				
I feel like a failure.				
I feel trapped or caught.				
My future seems hopeless.				
The pleasure and joy has gone out of my life.				
I feel depressed even when good things happen to me.				
Without trying to diet, I have lost, or gained weight.				
It is hard for me to concentrate on reading.				
It takes great effort for me to do simple things.				
I cry easily.				

Patient's Signature :_____ Date: _____

Reviewed By: _____ Date: _____