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

Headaches prior to TBI (*check one*):  Yes  No

*If “yes”, then answer the following questions regarding characteristics of pre-TBI headaches:*

*If “no”, then this completes the questionnaire.*

Does patient have a prior headache diagnosis? Yes  No *(If ‘Yes’, please 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\_\_\_\_\_\_\_\_

Date of first headache (month and year): \_\_/\_\_\_\_ (mm/yyyy)

*\*\* if exact date is not remembered, please select January as the month of the year that is remembered.*

Did the headache that was present prior to TBI change following TBI?  Yes  No

Are headaches more intense following TBI?  Yes  No

Are headaches more frequent following TBI?  Yes  No

Are headaches associated with new characteristics (e.g., changes in quality, location, or ‘associated symptoms’ such as nausea, vomiting, dizziness, or photophobia) following TBI?

Yes  No

If ‘Yes’, please select the new associated symptoms:

Nausea  Vomiting  Photophobia  Phonophobia  Dizziness (not vertigo)

Vertigo Throbbing pain  Pain with touching the scalp  Worsening of headache with routine physical activity like walking or climbing stairs

Prior to the TBI, how many days per month (30 days) did the individual have a headache of any duration (minutes or hours) of any severity (mild, moderate or severe)? \_\_\_/30

Prior to the TBI, what was the average *monthly* headache frequency of any kind with mild severity: \_\_\_/30

Prior to the TBI, what was the average *monthly* headache frequency of any kind with moderate severity: \_\_\_/30

Prior to the TBI, what was the average *monthly* headache frequency of any kind with severe severity: \_\_\_/30

Prior to the TBI, how many days per month (30 days) did the individual have complete headache freedom? \_\_\_/30

Were headaches prior to the TBI continuous (i.e., no periods of headache freedom)?

Yes  No

If headaches were not continuous, how long did headaches last if untreated/inadequately treated?

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

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

Right  Left  Front  Back  Side/Temples  Top

What side(s) was 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

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

Did the individual experience the following symptoms during headache:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Symptom | Never | Almost never | Sometimes | Often | | Almost Always |
| Nausea |  |  |  |  |  | |
| Vomiting |  |  |  |  |  | |
| Sensitive to light |  |  |  |  |  | |
| Sensitive to sound |  |  |  |  |  | |
| Neck Pain/Stiffness |  |  |  |  |  | |
| Dizziness and/or vertigo |  |  |  |  |  | |
| Gait and/or postural imbalance |  |  |  |  |  | |
| Difficulty with memory/concentration |  |  |  |  |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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)

Did the individual experience the following aura types with headaches:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Aura | Never | Almost never | Sometimes | Often | Almost Always |
| Visual |  |  |  |  |  |
| Sensory |  |  |  |  |  |
| Speech and/or language |  |  |  |  |  |
| Motor |  |  |  |  |  |
| Brainstem |  |  |  |  |  |
| Retinal |  |  |  |  |  |
| Other, specify |  |  |  |  |  |

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

Did the individual have the following symptoms on days without headache:

Nausea:  Yes  No

Vomiting:  Yes  No

Sensitivity to light:  Yes  No

Sensitivity to sound:  Yes  No

Neck Pain/Stiffness:  Yes  No

Dizziness and/or vertigo:  Yes  No

Gait and/or postural imbalance:  Yes  No

Difficulty with memory/concentration:  Yes  No

Aura without headache:  Yes  No

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:

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.