**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 Mother2 = Biological Father3 = Sibling Male4 = Sibling Female5 = Non-identical or dizygotic twin Male6 = Non-identical or dizygotic twin Female7 = Identical twin Male8 = Identical twin Female9 = Full biologic child Male10 = Full biologic child Female | 11 = Half-Sibling Male12 = Half-Sibling Female13 = Maternal Grandmother14 = Maternal Grandfather15= Paternal Grandmother16 = Paternal Grandfather17 = Maternal Aunt18 = Maternal Uncle19 = Paternal Aunt20 = Paternal Uncle21 = Grandchild Male22 = Grandchild Female23 = Nephew24 = 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.