

HEADACHE DISABILITY INDEX

Name: _____

Date: _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully:

The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES," "SOMETIMES," or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E1. Because of my headaches I feel handicapped.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F2. Because of my headaches I feel restricted in performing my routine daily activities.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E3. No one understands the effect my headaches have on my life.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F4. I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E5. My headaches make me angry.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E6. Sometimes I feel that I am going to lose control because of my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F7. Because of my headaches I am less likely to socialize.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E9. My headaches are so bad that I feel that I am going to go insane.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E10. My outlook on the world is affected by my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E11. I am afraid to go outside when I feel that a headache is starting.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E12. I feel desperate because of my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F13. I am concerned that I am paying penalties at work or at home because of my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E14. My headaches place stress on my relationships with family or friends.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F15. I avoid being around people when I have a headache.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F16. I believe my headaches are making it difficult for me to achieve my goals in life.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F17. I am unable to think clearly because of my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F18. I get tense (eg, muscle tension) because of my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F19. I do not enjoy social gatherings because of my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E20. I feel irritable because of my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F21. I avoid traveling because of my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E22. My headaches make me feel confused.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E23. My headaches make me feel frustrated.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F24. I find it difficult to read because of my headaches.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F25. I find it difficult to focus my attention away from my headaches and on other things.

Comments: _____

Signature: _____ Date: _____

Score: _____ Previous Score: _____ Examiner: _____