

# Headache Disability Index

## PATIENT INFORMATION

Full name: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:

Male  Female

Patient ID: \_\_\_\_\_ Contact number: \_\_\_\_\_

Email address: \_\_\_\_\_

Please select the correct response about your headaches:

1. I have a headache:

Once per month  More than once but less than four times per month  More than once per week

2. My headache is:

Mild  Moderate  Severe

Please read carefully: The purpose of this scale is to identify difficulties you may be experiencing because of your headaches. Please check Yes, Sometimes or No for each item. Answer each question only as it pertains to your headache.

1. Do you feel disabled because of your headache?

Yes  Sometimes  No

2. Do you feel restricted in performing your routine daily activities?

Yes  Sometimes  No

3. Do you feel no one understands the effect your headaches have on your life?

Yes  Sometimes  No

4. Do you restrict your recreational activities (for example, sports, hobbies) because of your headaches?

Yes  Sometimes  No

5. Do your headaches make you angry?

Yes  Sometimes  No

6. Do you feel that you are going to lose control because of your headaches?

Yes  Sometimes  No

7. Are you less likely to socialize because of your headaches?

Yes  Sometimes  No

8. Do you feel like your spouse (or significant other), family and friends have no idea what you are going through because of your headaches?

Yes  Sometimes  No

9. Do you feel your headaches are so bad that you will go insane?

Yes  Sometimes  No

10. Is your outlook on the world affected by your headaches?

Yes  Sometimes  No

11. Are you afraid to go outside when you feel a headache is starting?

Yes  Sometimes  No

12. Do you feel desperate because of your headaches?

Yes  Sometimes  No

13. Are you concerned that you are paying penalties at work or at home because of headaches?

Yes  Sometimes  No

14. Do your headaches place stress on your relationships with family or friends?

Yes  Sometimes  No

15. Do you avoid being around people when you have a headache?

Yes  Sometimes  No

16. Do you believe your headaches are making it difficult for you to achieve your goals in life?

Yes  Sometimes  No

17. Are you unable to think clearly because of your headaches?

Yes  Sometimes  No

18. Do you get tense (for example, muscle tension) because of your headaches?

Yes  Sometimes  No

19. Do you not enjoy social gatherings because of your headaches?

Yes  Sometimes  No

20. Do you feel irritable because of your headaches?

Yes  Sometimes  No

21. Do you avoid traveling because of your headaches?

Yes  Sometimes  No

22. Do your headaches make you feel confused?

Yes  Sometimes  No

23. Do your headaches make you feel frustrated?

Yes  Sometimes  No

24. Do you find it difficult to read because of your headaches?

Yes  Sometimes  No

25. Do you find it difficult to focus your attention away from your headaches and on other things?

Yes  Sometimes  No

Scoring instructions: Yes = 4 points, Sometimes = 2, No = 0. Using this system, a total score of 10-28 is considered to indicate mild disability; 30-48 is moderate disability; 50-68 is severe disability; 72 or more is complete disability.

## SCORING AND INTERPRETATION

### Scoring and interpretation

## ADDITIONAL NOTES

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Additional notes