Headache Disability Index

Patient information	
Full name: xxxxxxxxxxxxx	Age: xxxxxxxxxxxxxx
Gender: ◯ Male ◉ Female	Patient ID: xxxxxxxxxxx
Contact number: xxxxxxxxxx	Email address: xxxxxxxxx@xxxxx.com

Please check the correct response about your headaches:	
1. I have a headache:	2. My headache is:
◯ Once per month ◯ More than once but less than four times per month ◉ More than once per week	◯ 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.

	Yes	Sometimes	No
1. Do you feel disabled because of your headache?	◯	◉	◯
2. Do you feel restricted in performing your routine daily activities?	◉	◯	◯
3. Do you feel no one understands the effect your headaches have on your life?	◯	◉	◯
4. Do you restrict your recreational activities (for example, sports, hobbies) because of your headaches?	◉	◯	◯
5. Do your headaches make you angry?	◯	◉	◯
6. Do you feel that you are going to lose control because of your headaches?	◯	◉	◯
7. Are you less likely to socialize because of your headaches?	◯	◉	◯
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?	◯	◉	◯
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?	◉	○	○
11. Are you afraid to go outside when you feel a headache is starting?	◉	○	○
12. Do you feel desperate because of your headaches?	◉	○	○
13. Are you concerned that you are paying penalties at work or at home because of headaches?	◉	○	○
14. Do your headaches place stress on your relationships with family or friends?	○	◉	○
15. Do you avoid being around people when you have a headache?	◉	○	○
16. Do you believe your headaches are making it difficult for you to achieve your goals in life?	◉	○	○
17. Are you unable to think clearly because of your headaches?	◉	○	○
18. Do you get tense (for example, muscle tension) because of your headaches?	◉	○	○
19. Do you not enjoy social gatherings because of your headaches?	○	◉	○
20. Do you feel irritable because of your headaches?	◉	○	○
21. Do you avoid traveling because of your headaches?	◉	○	○
22. Do your headaches make you feel confused?	○	○	◉
23. Do your headaches make you feel frustrated?	◉	○	○
24. Do you find it difficult to read because of your headaches?	◉	○	○
25. Do you find it difficult to focus your attention away from your headaches and on other things?	◉	○	○

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.

Score and interpretation
Patient has a score of 78 indicating a complete disability.

Additional notes
Further evaluation is required to identify type and cause of headaches. Will proceed with a physical exam and interview.

Reference

TherapySouth. (2022). Headache Disability Index. https://therapysouth.com/wp-content/uploads/2022/04/Headache-Disability-Index-8.5x11.pdf