NAME: B.T. / A.T.:

O.D.D/I.P.D. DATE:

HIT-6™ Headache Impact Test

(To complete, please circle one answer for each question.)

1. When you have headaches, how often is the pain severe?

Never rarely sometimes very often always

2. How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

Never rarely sometimes very often always

3. When you have a headache, how often do you wish you could lie down?

Never rarely sometimes very often always

4. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

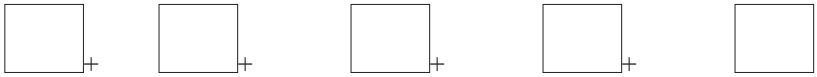
Never rarely sometimes very often always

5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

Never rarely sometimes very often always

6. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Never rarely sometimes very often always



COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5
6 points each	8 points each	10 Points each	11 Points each	13 Points each