

Pediatric Headache Master Intake Form

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Introduction: A modular system for pediatric headache evaluation was introduced in 2022 consisting of a separate questionnaire, history, and physical exam form.¹ While effective, the clinical landscape has evolved. The rise in recognized autonomic dysfunction, the persistence of regional neuroborreliosis, and the increasing prevalence of pressure-related pathologies in adolescents necessitate a more integrated approach. This updated 2-page Pediatric Headache Master Form consolidates those three instruments while expanding the diagnostic net for secondary headaches.

The Drive for Consolidation: Clinician efficiency is paramount. By merging three separate documents into one, the author has reduced “form fatigue” and ensures that the transition from patient-reported history to objective clinical exam is seamless. This consolidation ensures that critical links—such as the relationship between a toddler’s “periodic syndrome” and a teenager’s current migraine frequency—are not lost in fragmented paperwork.^{2,3}

Expanding the Differential: Gravity and Pressure: The 2025 update places a heavy emphasis on “gravity-dependent” symptoms. Since 2021, our understanding of the following has become essential for the general pediatrician:

- **Orthostatic Headaches & CSF Dynamics:** The form now includes specific “time-to-relief” metrics to screen for Spontaneous Intracranial Hypotension (SIH) and CSF leaks.⁴
- **Adolescent Pressure Headaches:** There are added markers for Idiopathic Intracranial Hypertension (IIH), which is increasingly observed in the teenage population. The inclusion of pulsatile tinnitus and “whooshing” ear sounds serves as a critical red flag for this demographic.^{5,6}
- **POTS & Autonomic Integration:** With the increased prevalence of Postural Orthostatic Tachycardia Syndrome (POTS), the form now mandates orthostatic vital signs, linking “coat-hanger” neck pain to autonomic instability.⁷

Infectious & Mechanical Updates: The master form

addresses the “migratory” nature of pain—a hallmark of Neuroborreliosis (Lyme Disease). By asking about shifting joint pain and radiculoneuritis alongside the headache history, clinicians can better identify Bannwarth’s Syndrome. Bannwarth’s Syndrome, or lymphocytic meningoradiculitis, is a severe neurological form of Lyme disease, characterized by intense, radiating nerve pain (radiculopathy), cranial nerve palsies (especially facial), and inflammation in the cerebrospinal fluid (CSF). Furthermore, the author has integrated a postural screen (Upper Crossed Syndrome) to address the mechanical “tech neck” prevalent in school-aged children.⁸

Expanding the Migraine Spectrum: Hormones & Auras:

The updated Master Form now accounts for the hormonal fluctuations of adolescence by including specific screening for menstrual migraines. Furthermore, the history section has been nuanced to differentiate between typical visual auras and more complex sensory or auditory hallucinations, ensuring a higher sensitivity for ICHD-3 classification.^{9,10}

Neuromusculoskeletal & Mechanical Differentiation:

To rule out mechanical triggers, the form now includes a targeted Neuromusculoskeletal Exam. This addresses the “tech-neck” epidemic by screening for:

- **Upper Crossed Syndrome:** Identifying the imbalance between tight pectorals/upper trapezius and weak deep neck flexors.¹¹
- **Cervicogenic Markers:** Evaluating the upper cervical spine (C0-C3) for segmental dysfunction that frequently mimics or triggers primary headaches.¹²
- **TMJ & Cranial Nerve Integrity:** Ensuring that jaw dysfunction or subtle cranial nerve deficits aren’t overlooked in the search for primary headache causes.¹³

Conclusion: While migraine and tension-type headaches remain the most common presentations, the “Master Form” ensures that the pediatrician is equipped to identify the pathological outliers. This tool provides a comprehensive, high-yield roadmap for the modern pediatric headache encounter.

Editor’s note: The two-page Pediatric Headache Master Form found on the following pages, which can be downloaded and printed, can be obtained as a single form, 8.5 by 14, by [clicking here](#), or following the link on the JCCP main web page.

References:

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PEDIATRIC HEADACHE MASTER INTAKE FORM

Patient Name: _____ DOB: _____ Date: _____

Informant: Patient Parent/Guardian Both _____

Email addresses _____ Telephone number _____ Consent to treat

Health History

Medications _____ Illness _____ Surgeries _____ Diagnoses _____

I. Primary Headache Characteristics

- Frequency: _____ per month | Duration: _____ hours/days.
- Intensity (0-4): ____ Location: Frontal Behind eyes Unilateral Occipital
- Quality: Throbbing/Pulsing Sharp/Stabbing Dull/Pressure Migratory
- Relieving Factors: Sleep Dark/Quiet Medications: _____ Other _____
- ADL Impact: Sports Socializing Computer.
- School days missed/month: _____ Parental input _____

II. Positional & Pressure Triggers (The “Gravity” Screen)

- Time to pain onset after STANDING: Immediate 1—10 mins >30 mins
- Does the pain resolve almost instantly when LYING FLAT? Yes No
- Pulsatile Tinnitus: Do you hear a “whooshing” sound like your heartbeat? Yes No
- Does pain “spike” with Coughing / Sneezing / Straining / Stairs? Yes No

III. Infection & Lyme Screen (Neuroborreliosis)

- Migratory Headache Pain: Yes No Exposure to endemic areas
- Systemic Signs: Known tick bite Recent “Bullseye” rash Migratory joint pain
- Neurological: Shooting pains in limbs Facial drooping/weakness Stiff neck

IV. Biomechanical & Lifestyle Triggers

- Triggers: Screen time Reading/Studying Physical exertion Stress
- Screen Time: Weekdays: _____ hrs | Weekends: _____ hrs | Ergonomics _____
- Vision: Last eye exam: _____ Can you see the board clearly? Yes No
- Sitting Position in classroom: _____ Spinal pain (Neck) _____
- Activities of Daily Living Affected: School Social Sports Other _____
- Parental input _____

V. Periodic Syndromes & Early History (Migraine Equivalents)

- Infancy: Colic Paroxysmal Torticollis/ Vertigo Head banging Seeks dark room
- Childhood: Abdominal pain Cyclical vomiting Motion sickness Parasomnias
- Sleep: Bruxism (grinding) Night terrors Snoring/Apnea Nightmares

VI. Trauma History Concussion Whiplash Mouth/Dental Trauma Significant Falls

VII. Psychosocial & Neurodevelopmental

- Conditions: ADHD/ADD ASP Anxiety Depression
- Environment: Bullying Abuse Counseling/Therapy
- Stress: at Home in School Gender Identity

VIII. Family History Migraine _____ Tension-Type Headache _____

CLINICAL HEADACHE EXAMINATION (Provider Use Only)

1. Vitals & Autonomic

- BP/HR (Supine): _____ / _____ BP/HR (Standing 5-min): _____ / _____ **
- Growth Curve: Ht: _____ % Wt: _____ HC: _____

2. Neuro-Musculo-Skeletal Examination

- Forward Head Posture Kyphosis & Upper Cross Syndrome Trigger points _____
- Lordosis / Scoliosis Torticollis / Plagiocephaly Laseue _____
- Spinal or Costovertebral dysfunction _____ Flexion-Rotation Test _____
- TMJ: TMJ dysfunction Palpatory tenderness Grinding teeth Tongue scalloping
- Neurological: CN exam _____ Fundoscopy Babinski _____
- Visual Tracking: Smooth pursuit _____ Nystagmus _____ Accommodation _____
- Reflexes/Sensation/Strength _____ Gait _____
- Single Leg Stance (Eyes Open/Closed) _____ Romberg & Heel-to-Toe _____
- Meningeal signs: Kernig's Brudzinski's | Spinal ROM _____

3. Differential Diagnostic Impression

Vascular: Tinnitus/Dizziness Migraine with aura

Aura: Visual disturbances Feeling pins/needles Auditory hallucinations Osmophobia

Primary HA: Migraine without Aura TTH

Hormonal influence on headache _____

- CSF pressure: SIH (Leak) IIH (High Pressure) Chiari I
- Infectious: Neuroborreliosis (Lyme)
- Mechanical: Cervicogenic TMJ POTS

RED FLAGS REQUIRING IMMEDIATE IMAGING/ED REFERRAL

- Thunderclap Onset: Sudden “worst headache of life.”
- Nocturnal Awakening: Waking up at night specifically to vomit.
- Focal Neuro Deficit: Cranial nerve palsy, ataxia, or papilledema.
- Age < 5 Years: Any persistent headache in a very young child.

** “BP Change >20mmHg or HR >40bpm = Positive Orthostatic Screen”