

Capital Institute for Neurosciences

Dr. Mitra Assadi

Hit-6 (Version II)

HEADACHE IMPACT TEST

Date: _____

Patient Name: _____ DOB: _____

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

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