# Patient Questionnaire

## HIT – 6 ™ Headache Impact Test

This questionnaire was designed to help you describe and communicate the way you feel and what you **cannot do** because of the 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** |
| Total | | | | | |
| | (6 points each) | (8 points each) | (10 points each) | (11 points each) | (13 points each) |

To score, add points for answers in each column. TOTAL SCORE: ________

Please share your HIT-6 ™ results with your doctor.