Additional File 2: Headache Questionnaire in English.

Questions about your headache

Thank you for taking the time to complete this survey. This questionnaire will take about 5 minutes to complete.

1. What is your serial number?

_____

2. What is your gender?

(Male / Female / Other)

3. What is your age?

_____ years old.

4. Please check the name of the headache diagnosis you received at Tominaga Hospital.

☐A. Migraine (Migraine with aura, migraine without aura, or chronic migraine)

☐B. Infrequent episodic tension-type headache ☐E. Migraine + Tension-type headache

☐C. Frequent episodic tension-type headache ☐F. Medication-overuse headache

☐D. Chronic tension-type headache

5. We will now ask you some questions about your headaches. Please circle the answer that applies to you. Please answer the questions in the order that they appear, starting with Q1.

Q1: Have you ever experienced a headache?

(Yes ・ No)

Q2: Have you ever experienced headaches with similar symptoms over and over again?

(Yes ・ No)

Q3: How many times in your life have you experienced these headaches?

(2‐4 times ・ 5–10 times ・ more than 10 times)

Q4: Have you had headaches over a certain amount of time in the last three months?

(Yes ・ No)

Q5a: How long does one headache last if not treated with medication, therapy, or other measures? Please check the box that applies most to you.

☐Less than 30 minutes	☐Between 4 hours and 1 day	☐Constant and persistent
☐Between 30 minutes and 1 hour	☐Between 1 and 3 days	
☐Between 1 and 4 hours	☐Between 3 and 7 days	
☐Other ( )		

Q5b: If you take medication, have therapy, or use other measures to alleviate a headache, how long does each headache last? Please check the box that applies most to you.

☐Less than 30 minutes	☐Between 4 hours and 1 day	☐Constant and persistent
☐Between 30 minutes and 1 hour	☐Between 1 and 3 days	
☐Between 1 and 4 hours	☐Between 1 and 7 days	
☐Other ( )		

Q6: How often do you get headaches? Please check only one of the following.

☐Less than one day per month

☐Less than 15 days per month

☐More than 15 days per month

☐A few hours to a few days or incessantly

Q7: What is the average intensity of your pain? Please check only one of the following.
(Weak ・ Weak to medium ・ Medium ・ Medium to strong ・ Strong)

Q8a: On which side of your head is the pain located? Please check one of the following.

☐Always on the right side	☐Always on one side, but sometimes on the right and sometimes on the left	
☐Always on the left side	☐Sometimes on both sides, sometimes on one side	☐Always on both sides

Q8b: If you checked " Always on one side, but sometimes on the right and sometimes on the left " or " Sometimes on both sides, sometimes on one side " in Q8a, please answer the following: When you have a headache, what percentage of the time is it i) on both sides, ii) on only the right side, and iii) on only the left side?

i)_____ii)_____iii)_____

Q8c: Please check one of the following regarding average pain intensity.

☐Same for left and right sides	☐Left is worse than right side
☐Right is worse than left side	☐Sometimes right is worse and sometimes left is worse

Q9: Please check the appropriate box for the nature of your pain. If you choose "other," please provide specific details in parentheses.

☐Throbbing pain that feels like it is in time with my pulse
☐Heavy pain that feels as if it is squeezing
☐Other（ ）

Q10: Regarding the nature of your pain, please check "Yes" or "No" for the following items.

Q10a: Does your pain worsen with daily activities such as walking or going up and down stairs? (Yes ・ No)

Q10b: Do you avoid such daily activities when you have a headache? (Yes ・ No)

Q11: Please answer the following questions regarding your other symptoms during headaches.

Q11a: Do you have nausea? (Yes ・ No)

Q11b: Do you throw up? (Yes ・ No)

Q11c: Do you become sensitive to light and feel dazzled by light? (Yes ・ No)

Q11d: Do you become sensitive to sound and do things seem noisy? (Yes ・ No)

Q12a: Do you ever take medication for headaches? (Yes ・ No)

Q12b: Do you take any of the following medications for headaches?
（ Prescription medications (including triptans) ・ Prescription medications (painkillers only, no triptans) ・ Others)

Q12c: Have you regularly taken any pain medication for headaches for over three months at a time? (Yes ・ No)

Q12d: How often do you take this medication?

☐More than 15 times a month	☐2-4 times a month
☐10-14 times a month	☐Once a month
☐5-9 times a month	☐Less than once a month

Q13: Before a headache occurs, do you experience an aura? This can include visual symptoms, sensory symptoms, language symptoms, motor symptoms, brainstem symptoms, and/or retinal symptoms.

(Yes, an aura is present ・ No, an aura is not present)

Q14: Does the aura before a headache last 5 to 60 minutes?

(Yes ・ No)

Q15: Please tell us what you think about this questionnaire (what was challenging to understand, what questions you felt were necessary or unnecessary, etc.).

That is all for the questions.

I appreciate your participation.

This questionnaire will assist in the development of a screening tool for headaches.

(This questionnaire is not a back-translation.)