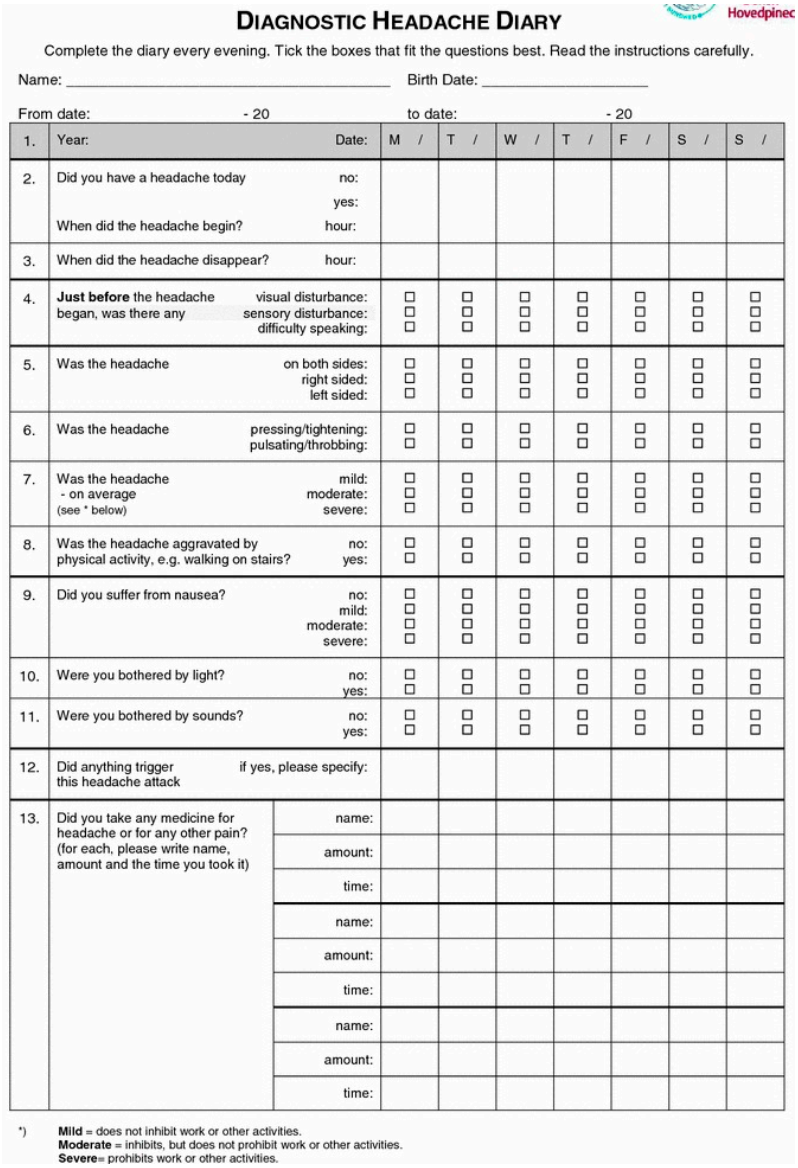
Supplementary Figure S1. Diagnostic headache diary



DIAGNOSTIC HEADACHE DIARY

Hovedpinec

Complete the diary every evening. Tick the boxes that fit the questions best. Read the instructions carefully.

Name: _____ Birth Date: _____

From date: - 20 to date: - 20

1.	Year:	Date:	M /	T /	W /	T /	F /	S /	S /
2.	Did you have a headache today	no: yes:							
	When did the headache begin?	hour:							
3.	When did the headache disappear?	hour:							
4.	**Just before** the headache began, was there any	visual disturbance: sensory disturbance: difficulty speaking:	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
5.	Was the headache	on both sides: right sided: left sided:	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
6.	Was the headache	pressing/tightening: pulsating/throbbing:	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
7.	Was the headache - on average (see * below)	mild: moderate: severe:	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
8.	Was the headache aggravated by physical activity, e.g. walking on stairs?	no: yes:	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
9.	Did you suffer from nausea?	no: mild: moderate: severe:	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
10.	Were you bothered by light?	no: yes:	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
11.	Were you bothered by sounds?	no: yes:	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
12.	Did anything trigger this headache attack	if yes, please specify:							
13.	Did you take any medicine for headache or for any other pain? (for each, please write name, amount and the time you took it)	name: amount: time: name: amount: time: name: amount: time:							

*) **Mild** = does not inhibit work or other activities.
Moderate = inhibits, but does not prohibit work or other activities.
Severe= prohibits work or other activities.

Supplementary Figure S2. Information box regarding Tension-type Headache Information box regarding Migraine

With tension-type headache at least 2/4 of the following must be fulfilled:

- Moderate/mild pain intensity
- Pain located on both side of the head.
- The pain is pressing/tightening.
- Not aggravated by routine physical activity

Besides there can be sound- or light sensitivity, but no nausea.

With migraine at least 2/4 of the following must be fulfilled:

- Moderate/severe pain intensity
- Pain is most prominent on one side of the head.
- The pain is pulsatile/pounding.
- Aggravation by routine physical activity

Besides there can be at least 1/2:

- Nausea
- Sound-or light sensitivity