

Impact of Headaches and Migraine on Art Making Practices Survey

1. Age: _____ years Year of birth: 19____ Gender: Female _____ Male _____

2. Which one of the following statements best describes you:

- I am a full-time, professional artist (or art student)
- I work part-time as an artist (or art student)
- Art is my main hobby
- I make art occasionally
- I rarely make art

Additional comments: _____

3. On average, how many hours per week do you make art? _____ hours

4. What is your medium of choice?

5. Are you now, or have you ever been, significantly bothered by recurrent headaches?

yes _____ no _____ (if no, go to question 25)

6. Were those headaches found by your physicians to be due to a definite cause (e.g., severe head or neck trauma, brain tumor, meningitis, aneurysm, stroke)?

yes _____ (if yes, specify _____)

no _____

7. How long have you experienced those recurrent headaches?

For _____ years

8. Have you had at least five separate attacks of headache severe enough to require that you stop or decrease your activities or take a medication for pain?

yes _____ no _____ (if no, go to question 16)

9. Do you have (had) pain-free intervals of days to weeks between severe headache attacks?

yes _____ no _____

10. Do your headache attacks usually last more than four hours and less than three days?
yes ____ no ____ (if no, go to question 16)

11. Are your most bothersome headaches
- often pulsating ("throbbing")? yes ____ no ____
 - often unilateral (left or right side of head) for at least a portion of the headache attack? yes ____ no ____
 - severe enough to cause you to stop or decrease your activities? yes ____ no ____
 - made worse by physical activity? yes ____ no ____

12. Are your headache attacks accompanied by:

- nausea or vomiting? yes ____ no ____
- sensitivity to light? yes ____ no ____
- sensitivity to noise? yes ____ no ____

13. With at least two of your headache attacks have you had temporary visual disturbances (e.g., shimmering lights, zigzags, blind spots, circles, crescent shapes) just before or during the headache?
yes ____ no ____

a. If yes which if the following best describes your visual disturbance (more than one answer may be given):

- ____ silver streaks
- ____ white lights
- ____ light objects appearing excessively bright
- ____ all objects appearing gray or yellow
- ____ distortion of all linear objects
- ____ dancing and moving cobwebs
- ____ moving black veils
- ____ scintillating picket fences
- ____ silver stars
- ____ heat waves
- ____ flashing gold lights
- ____ 4th of July sparklers
- ____ zigzag streaks of light
- ____ herringbone pattern
- ____ double vision
- ____ blind spot
- ____ none of the above (describe yours _____)

b. Does the visual disturbance go away completely within 60 minutes? yes ____ no ____

c. How long does the visual disturbance last (in minutes)? ____

d. Does the visual disturbance change (e.g. worse, change character) within four minutes?
yes ____ no ____

e. Is the visual disturbance associated with headache, nausea, and/or light sensitivity immediately or within 60 minutes? yes ____ no ____

14. With at least two of your headache attacks have you had temporary numbness, tingling, or both involving the lips, tongue, fingers, or legs, occurring just before or during the headache?
yes ____ no ____

15. Have you had headaches accompanied by both visual disturbances and temporary numbness/tingling? yes ____ no ____

16. Have you ever noticed a tendency for your art making activities to alter the frequency, duration, or severity of your headaches/migraines in any of the following ways:

- a. Triggering a headache/migraine: yes ____ no ____
- b. Worsening a headache/migraine: yes ____ no ____
- c. Alleviating a headache/migraine: yes ____ no ____
- d. Lessening a headache/migraine: yes ____ no ____

Comments: _____

17. Have you noticed any particular art materials (colour, odour ...), art making processes (physical or mental) or related studio working conditions (lighting, ventilation ...) that:

- a. Trigger your headache/migraine: yes ____ no ____
- b. Worsen your headache/migraine: yes ____ no ____
- c. Alleviate your headache/migraine: yes ____ no ____
- d. Lessen your headache/migraine: yes ____ no ____

Comments: _____

18. In light of these observations, what steps, if any, have you taken to alter your art making conditions?

Comments: _____

19. Which of the following statements best describes the quality of your art in relation to your headaches/migraines:

- Ⓐ My art gets noticeably better when I work with a headache/migraine
- Ⓑ My art gets somewhat better when I work with a headache/migraine
- Ⓒ My art gets somewhat worse when I work with a headache/migraine
- Ⓓ My art gets noticeably worse when I work with a headache/migraine
- Ⓔ My art appears unaffected by my headaches/migraines

Comments: _____

20. Which of the following statements best describes your art production in relation to your headaches/migraines:

- I always work on my art with headaches/migraines
- I usually work on my art with headaches/migraines
- I sometimes work on my art with headaches/migraines
- I rarely work on my art with headaches/migraines
- I never work on my art with headaches/migraines

Comments: _____

21. Which one of the following statements best describes the relationship between your art making and headache/migraine experiences:

- I see no relationship between my art making and headaches/migraines _____
- I see some relationship between my art making and headaches/migraines _____
- I see a strong relationship between my art making and headaches/migraines _____
- I see a direct relationship between my art making and headaches/migraines _____

Comments: _____

22. In question 13a, you have been asked to record any visual symptoms that you may have experienced in association with your headaches/migraines. Have you ever noticed any of these reflected in your art? yes _____ no _____

Comments: _____

23. If yes, have you ever deliberately depicted any of these in your art? yes _____ no _____

Comments: _____

24. Have you ever used any of your headache/migraine experiences as a source of artistic inspiration? yes _____ no _____

25. Do you consider yourself being a migraine sufferer? yes _____ no _____

Comments: _____

26. Would you be willing to give us the opportunity to be called with follow-up questions to this survey? yes _____ no _____

If yes, please list your name, phone or e-mail and best times at which you may be reached:

Name:

Email:

Phone:

Times you can be reached:

Additional comments are welcome, please attach a separate sheet if needed. Thank you for your participation!