Head Pain Questionnaire

Please Only Fill This Form Out If YOU Are Experiencing This Pain!

If You Do Not Have This Pain Then Skip This Form!

1. Where in your Head are you feeling pain?

   Front Back Left Side Right Side

2. How would you rate the level of your pain you feel right now on a scale of 1 to 10? **One is no pain, ten is severe pain.**

   1 2 3 4 5 6 7 8 9 10

3. What is the frequency of pain? How often do you feel the pain?

   0-25% 25-50% 50-75% 75-100%

4. When the pain is at its worst what number would you rate it?
   One is no pain, ten in severe pain.

   1 2 3 4 5 6 7 8 9 10

5. When the pain is at its best what number would you rate it?

   One is no pain, ten in severe pain.

   1 2 3 4 5 6 7 8 9 10

6. Does your pain refer to any of the following areas?

Neck	Face	Jaw	Eyes
Left-Right or Both	Left-Right or Both	Left-Right or Both	Left-Right or Both

7. What relieves your pain?

   Rest Ice Heat Stretching Medicine type: _____

Patient Name: _____

8. When you do get relief what percentage does your pain improve?

0-25% 25-50% 50-75% 75-100%

9. How would you describe the pain?

Sharp Dull Achy Stiff Tight Burning Numb

10. When is the pain at its worst?

Morning Afternoon Evening All Day

11. What caused this pain? What were you doing when you first felt the pain?

_____

_____

Patient Name: _____