Healing Hands Massage & Holistic Therapies
Headache Questionnaire

Name_____ Date_____

Check the statements that apply to you:

_____ I have a headache right now.

_____ I have taken medication within the last four hours. (Name of meds)

_____

_____ I have seen other medical professionals to help me with my headaches.

a. Name_____Date_____Diagnosis_____

b. Name_____Date_____Diagnosis_____

I get headaches

_____ Every day
_____ Once a week
_____ Several times a week
_____ Several times a month
_____ Rarely
_____ Other_____

My headache is accompanied by:

_____ blurred vision and/or pain behind the eyes
_____ A fever
_____ A stiff neck and/or sensitivity to light
_____ Persistent throbbing in my head
_____ Mental confusion
_____ Severe pain that radiates to my neck are

I can also say that:

_____ I have recently experienced a blow to the head, a fall, or an accident
_____ My pain starts when I turn my head quickly to the side
_____ My pain gets worse when lying down and improves by being upright
_____ I get strong headaches that awaken me in the night
_____ I get headaches following activities in which I strain or exert myself
_____ This is the worst pain I have had in my life

Describe your headache pain in your own words:_____

_____

_____

List any factors that you think have contributed to your having a headache: _____

_____

_____

List all medication you are taking currently, both prescription and other: _____

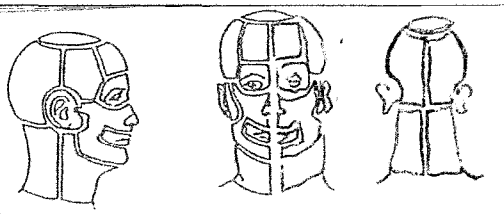
_____

_____

_____

_____

Color in the areas where you feel your pain on these diagrams:



Signature_____