Balanced Body Massage

Headache Assessment Form

*Where is your pain located?*_____

*Does your pain refer to other areas? Yes/No Where?*_____

*When did this pain begin?*_____ *How often does it occur?*_____

*Have you experienced pain similar to this before? Yes/No When?*_____

Please grade the following questions on a scale of 1-10, 1 being pain free and 10 being the most severe pain you have ever experienced.

_____ *Pain while trying to go to sleep*

_____ *Pain that wakes you from sleep*

_____ *Pain when waking in the morning*

_____ *Pain at lunchtime*

_____ *Pain after working all day*

_____ *Pain at dinnertime*

_____ *Pain during your typical evening*

*How many hours do you typically sleep uninterrupted by pain or discomfort?*_____

*What activities, if any, are you limited from participating in?*_____

*What makes the pain better/worse?*_____

*How much water (with nothing added) do you consume daily?*_____

*How often do you exercise?*_____

*On a scale of 1-100 rate your over all wellness*_____

_____ _____

Client Name Printed *Licensee's Name Printed*

_____ _____

Client Signature *Date* *Licensee's Signature* *Date*

Thank You!