Baltimore Holistic Physical Therapy
LIVE LIFE WELL

PATIENT QUESTIONAIRE FOR HEADACHES, NECK and FACIAL PAIN

NAME_____ DATE_____

Circle each over- the- counter medications you take: aspirin, ibuprofen/Advil/Motrin/Aleve, Tylenol, decongestants, antihistamines, laxatives, antacids, vitamin/mineral supplements, other _____

What situations cause stress to you?

_____

When do you remember an initial onset of headache/neck/facial pains?

_____

What appears to precipitate the headache/neck/facial pain?

_____

How often do you get headache/neck/facial pain?

_____

How long does the headache/neck/facial pain last?

_____

What do you do to relieve the headache/neck/facial pain?

_____

Do you have any of the following?

yes no Pain, numbness or tingling in any of your limbs (arms, legs)

yes no Recent weakness

yes no Memory loss/confusion

Yes no Difficulty concentrating on a task

yes no Difficulty sleeping at night

yes no Sensitivity to light

yes no Sensitivity to sound

yes no Nausea or vomiting

yes no Ever hit your head hard or gotten hit in the head with an object

yes no Symptoms worse during a particular time(s) of the day

yes no Get fatigued easily

yes no Does your headache worsen with reading

yes no Have you ever been told that you grind your teeth

yes no Have you ever been told to wear a night guard? Do you currently wear one?

yes no Have you recently undergone any dental work or had to keep your mouth open >15min?

yes no Do you wear dentures?

yes no Do you have any pain, popping or clicking in your jaw?

yes no Do you have difficulty breathing through one or both sides of your nose?

yes no Have you ever fallen hard on your tail bone/buttocks?

Do you ever experience:

yes no Facial pressure or pain

yes no Sinus congestion

yes no Post- nasal drip

yes no Diminished sense of smell

yes no Need to clear your throat often

yes no Ear pressure, crackling, clogging

yes no Chronic watery eyes

yes no Recent sinus infection