

# PAIN MANAGEMENT ASSESSMENT

## PAIN HISTORY FOR HEADACHE

PATIENT NAME:

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**FORMRETURN™**

Optical Mark Recognition Made Simple

[www.formreturn.com](http://www.formreturn.com)

Optical Mark Recognition Software

- Design OMR Forms and Automatically Capture Checkbox  
Response Marks -

- Print to Spreadsheet -

Process hundreds of Forms in Minutes.

### IMPORTANT INFORMATION:

This form will be computer marked:  
Using a dark pen, shade in the  
checkbox bubble of your choice.

Q1. How Often?

- Daily - Once a Day
- Daily - Several times a Day
- Weekly - Once a Week
- Weekly - Several times a Week
- Monthly - Once a Month
- Monthly - Several times a Month

Q3. Pattern?

- Entire head
- Head and neck.
- Left - sided
- Right - sided.
- Back of head.
- Temples.
- In / around the eyes.
- Radiates to.



Q2. Associated With?

- Light / sound sensitivity.
- Nausea / vomiting
- Visual disturbances.
- Seizures
- Passing out.
- Loss of bowel / bladder function
- Menstruation

### DIAGNOSTIC STUDIES

- MRI -----
- CT -----
- X-rays -----

### PHYSICIAN NOTES:

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