

<b>HEAD PAIN</b>	
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50%  <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%
Pain/Severity	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling / <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Associated with	<input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Decreased ROM <input type="checkbox"/> Dizziness <input type="checkbox"/> Increased Sensitivity  <input type="checkbox"/> Inflammation <input type="checkbox"/> Sensitivity to Bright Light <input type="checkbox"/> Shallow Breathing
Radiates to	<input type="checkbox"/> Ears <input type="checkbox"/> Eyes <input type="checkbox"/> Face <input type="checkbox"/> Left Ear <input type="checkbox"/> Left Eye <input type="checkbox"/> Left Jaw <input type="checkbox"/> Neck  <input type="checkbox"/> Right Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Right Jaw <input type="checkbox"/> Shoulder (Left/ Right)
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing
At its worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night  After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting  <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing
What makes it worse?	<input type="checkbox"/> Bending <input type="checkbox"/> Bright lights <input type="checkbox"/> Chewing <input type="checkbox"/> Closing mouth  <input type="checkbox"/> Deep Breathing <input type="checkbox"/> Extension <input type="checkbox"/> Grasping <input type="checkbox"/> Housework  <input type="checkbox"/> Loud Noises <input type="checkbox"/> Neck Movement <input type="checkbox"/> Pushing