

# HEAD, NECK AND FACIAL PAIN QUESTIONNAIRE

Form 401A

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

## PATIENT INFORMATION

TODAY'S DATE \_\_\_\_\_

MR.  MS.  MISS  MRS.  DR. NAME: \_\_\_\_\_

First Middle Initial Last

AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_  MALE  FEMALE

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SS#: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

MARITAL STATUS:  Single  Married  Widowed  Divorced  Other

RESPONSIBLE PARTY: \_\_\_\_\_

FAMILY DENTIST: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

## WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe symptom, #2 the next, etc.

2. Then rate your complaints for frequency and intensity:

### Frequency:

(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

### Intensity:

(0 is NO PAIN and 10 is MOST SEVERE PAIN)

Number	Frequency	Intensity
#1 = the most severe symptom	1-4	0-10
_____ Back Pain	_____	_____
_____ Dizziness	_____	_____
_____ Ear Congestion	_____	_____
_____ Ear Pain	_____	_____
_____ Eye Pain	_____	_____
_____ Facial Pain	_____	_____
_____ Fatigue	_____	_____
_____ Headaches	_____	_____
_____ Inability to open mouth	_____	_____
_____ Jaw Clicking	_____	_____
_____ Jaw Joint Noises	_____	_____
_____ Jaw Locking	_____	_____
_____ Jaw Pain	_____	_____
_____ Limited Mouth Opening	_____	_____
_____ Migraine Headaches	_____	_____
_____ Muscle Twitching	_____	_____
_____ Neck Pain	_____	_____
_____ Pain when Chewing	_____	_____
_____ Ringing in the Ears	_____	_____
_____ Shoulder Pain	_____	_____
_____ Sinus Congestion	_____	_____
_____ Throat Pain	_____	_____
_____ Visual Disturbances	_____	_____
Other - write in:	_____	_____
_____	_____	_____
_____	_____	_____

#1 = the most severe symptom

1-4 0-10

\_\_\_\_\_ Back Pain

\_\_\_\_\_ Dizziness

\_\_\_\_\_ Ear Congestion

\_\_\_\_\_ Ear Pain

\_\_\_\_\_ Eye Pain

\_\_\_\_\_ Facial Pain

\_\_\_\_\_ Fatigue

\_\_\_\_\_ Headaches

\_\_\_\_\_ Inability to open mouth

\_\_\_\_\_ Jaw Clicking

\_\_\_\_\_ Jaw Joint Noises

\_\_\_\_\_ Jaw Locking

\_\_\_\_\_ Jaw Pain

\_\_\_\_\_ Limited Mouth Opening

\_\_\_\_\_ Migraine Headaches

\_\_\_\_\_ Muscle Twitching

\_\_\_\_\_ Neck Pain

\_\_\_\_\_ Pain when Chewing

\_\_\_\_\_ Ringing in the Ears

\_\_\_\_\_ Shoulder Pain

\_\_\_\_\_ Sinus Congestion

\_\_\_\_\_ Throat Pain

\_\_\_\_\_ Visual Disturbances

Other - write in:

<p>Patient Signature</p> <p>_____</p> <p>Date _____</p>
---

**LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:**

- |  |   |  |
|--|---|--|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics  | Y <input type="checkbox"/> N <input type="checkbox"/> Latex             | Y <input type="checkbox"/> N <input type="checkbox"/> Sedatives      |
| Y <input type="checkbox"/> N <input type="checkbox"/> Aspirin      | Y <input type="checkbox"/> N <input type="checkbox"/> Local anesthetics | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates | Y <input type="checkbox"/> N <input type="checkbox"/> Metals            | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs    |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine      | Y <input type="checkbox"/> N <input type="checkbox"/> Penicillin        | Y <input type="checkbox"/> N <input type="checkbox"/> Other _____    |
| Y <input type="checkbox"/> N <input type="checkbox"/> Iodine       | Y <input type="checkbox"/> N <input type="checkbox"/> Plastic           | _____  |

**LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:**

- |  |  |   |
|--|--|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics    | Y <input type="checkbox"/> N <input type="checkbox"/> Cortisone        | Y <input type="checkbox"/> N <input type="checkbox"/> Nerve pills     |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anticoagulants | Y <input type="checkbox"/> N <input type="checkbox"/> Diet pills       | Y <input type="checkbox"/> N <input type="checkbox"/> Pain medication |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates   | Y <input type="checkbox"/> N <input type="checkbox"/> Heart medication | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood thinners | Y <input type="checkbox"/> N <input type="checkbox"/> Insulin          | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs     |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine        | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle relaxants | Y <input type="checkbox"/> N <input type="checkbox"/> Tranquilizers   |

Other \_\_\_\_\_

**PLEASE LIST ANY TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:**

Practitioner	Specialty	Treatment & approximate date
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		

**MEDICAL HISTORY (Please indicate dates on questions checked YES)**

- |   |   |   |
|---|---|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Adenoids Removed  | Y <input type="checkbox"/> N <input type="checkbox"/> Current pregnancy             | Y <input type="checkbox"/> N <input type="checkbox"/> General anesthesia    |
| Y <input type="checkbox"/> N <input type="checkbox"/> Tonsils Removed   | Y <input type="checkbox"/> N <input type="checkbox"/> Depression                    | Y <input type="checkbox"/> N <input type="checkbox"/> Glaucoma              |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anemia  | Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes                      | Y <input type="checkbox"/> N <input type="checkbox"/> Gout                  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Arteriosclerosis  | Y <input type="checkbox"/> N <input type="checkbox"/> Difficulty concentrating      | Y <input type="checkbox"/> N <input type="checkbox"/> Hay fever             |
| Y <input type="checkbox"/> N <input type="checkbox"/> Asthma  | Y <input type="checkbox"/> N <input type="checkbox"/> Dizziness                     | Y <input type="checkbox"/> N <input type="checkbox"/> Hearing impairment    |
| Y <input type="checkbox"/> N <input type="checkbox"/> Autoimmune disorders  | Y <input type="checkbox"/> N <input type="checkbox"/> Emphysema                     | Y <input type="checkbox"/> N <input type="checkbox"/> Heart murmur          |
| Y <input type="checkbox"/> N <input type="checkbox"/> Bleeding easily   | Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy                      | Y <input type="checkbox"/> N <input type="checkbox"/> Heart disorder        |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood pressure <input type="checkbox"/> High <input type="checkbox"/> Low | Y <input type="checkbox"/> N <input type="checkbox"/> Excessive thirst              | Y <input type="checkbox"/> N <input type="checkbox"/> Heart pacemaker       |
| Y <input type="checkbox"/> N <input type="checkbox"/> Bruising easily   | Y <input type="checkbox"/> N <input type="checkbox"/> Fibromyalgia                  | Y <input type="checkbox"/> N <input type="checkbox"/> Heart palpitations    |
| Y <input type="checkbox"/> N <input type="checkbox"/> Cancer  | Y <input type="checkbox"/> N <input type="checkbox"/> Fluid retention               | Y <input type="checkbox"/> N <input type="checkbox"/> Heart valve replaceme |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chemotherapy  | Y <input type="checkbox"/> N <input type="checkbox"/> Frequent cough                | Y <input type="checkbox"/> N <input type="checkbox"/> Hemophilia            |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chronic fatigue   | Y <input type="checkbox"/> N <input type="checkbox"/> Frequent illnesses            | Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis             |
| Y <input type="checkbox"/> N <input type="checkbox"/> Cold hands & feet   | Y <input type="checkbox"/> N <input type="checkbox"/> Frequent stressful situations | Y <input type="checkbox"/> N <input type="checkbox"/> Hypoglycemia          |

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**DIAGNOSTIC RECORDS**      REQUIRED DIAGNOSTIC RECORDS INCLUDE:

- |  |  |
|--|--|
| <input type="checkbox"/> Axiographic tracking of mandibular movements (21299)    | <input type="checkbox"/> Joint vibration analysis (77077)      |
| <input type="checkbox"/> Computerized mandibular scanning (97750)                | <input type="checkbox"/> Mandibular position indicator (21499) |
| <input type="checkbox"/> Chronic pain psychosocial analysis (96100)              | <input type="checkbox"/> Myofunctional analysis (97112)        |
| <input type="checkbox"/> Computerized sonography (77077)                         | <input type="checkbox"/> Orthopedic diagnostic splint          |
| <input type="checkbox"/> Diagnostic anesthetic block (90782)                     | <input type="checkbox"/> Orthopedic jaw casts (A4580)          |
| <input type="checkbox"/> Doppler studies of the temporomandibular joints (93875) | <input type="checkbox"/> Photographic documentation (99070)    |
| <input type="checkbox"/> Dysphagia-swallow analysis                              | <input type="checkbox"/> Thermography (93760)                  |
| <input type="checkbox"/> Electrognathic studies (97750)                          | <input type="checkbox"/> TMJ scale (96100)                     |
| <input type="checkbox"/> Electromyographic studies of muscle activity (S3900)    | <input type="checkbox"/> Video documentation (99080)           |
|  | <input type="checkbox"/> Other _____                           |

**DIAGNOSIS/ASSESSMENT**

<p><b>Evaluation Type:</b></p> <p><input type="checkbox"/> A diagnosis</p> <p><input type="checkbox"/> A final diagnosis</p> <p><input type="checkbox"/> A working diagnosis</p> <p><input type="checkbox"/> An initial clinical impression</p>
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Unspecified codes marked with an asterisk (\*) may not be recognized by insurers. Select specific codes when possible.

- |   |   |   |  |
|---|---|---|--|
| L | R | B | Condylar hyperplasia (acquired) (526.89) * |
| L | R | B | Condylar hypoplasia (acquired) (526.89) *  |
| L | R | B | Degenerative arthritis (524.69) *          |
|   |   |   | (Other specified TMJ disorders)            |

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | Abnormal jaw closure (524.51)  |
| L R B                    | Ankylosis of the temporomandibular joint (524.61)  |
| <input type="checkbox"/> | Anomalies of relationship of jaw to cranial base (unspecified anomaly) (524.10)  |
| L R B                    | Anterior disc displacement with reduction (524.63)   |
| L R B                    | Anterior disc displacement without reduction (524.63)  |
| L R B                    | Articular cartilage disorder (524.63)  |
| L R B                    | Atypical facial pain (350.2)   |
| <input type="checkbox"/> | Bell's palsy (351.0)   |
| L R B                    | Bone spur, unspecified (726.91) *  |
| L R B                    | Capsulitis of the temporomandibular joint (Enthesopathy of unspecified site, Capsulitis NOS, Periarthritis NOS) (726.90) * |
| <input type="checkbox"/> | Carotidynia (337.0)  |
| L R B                    | Cephalgia (facial pain, pain in head) (784.0)  |
| L R B                    | Cervicalgia (723.1)  |
| <input type="checkbox"/> | Chronic paroxysmal hemicrania (346.8)  |
| L R B                    | Closed lock of the TMJ (830.0)   |
|                          | <input type="checkbox"/> The lock is intermittent  |

<p><b>Dentofacial functional abnormalities, other (524.59)</b></p> <p><input type="checkbox"/> Abnormal swallowing</p> <p><input type="checkbox"/> Mouth breathing</p> <p><input type="checkbox"/> Sleep posture</p> <p><input type="checkbox"/> Tongue, lip or finger habits</p>
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- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | Deviation in opening and closing of the mandible (524.53)                   |
| L R B                    | Dislocation of the jaw, closed (830.0)                                      |
| L R B                    | Dislocation of the jaw, open (830.1)  |
| <input type="checkbox"/> | Dizziness (780.4)   |
| <input type="checkbox"/> | Dysphasia, oral phase (787.21)  |
| <input type="checkbox"/> | Dysphagia, oropharyngeal phase (787.22)                                     |
| L R B                    | Eagles syndrome (Other disorders of muscle, ligament and fascia) (728.89) * |
| L R B                    | Ernest syndrome (Other peripheral enthesopathies) (726.8) *                 |
| <input type="checkbox"/> | Exam of individual involved in MV traffic accident (V71.4)                  |
| L R B                    | Facial/cervical myositis (729.1) *  |
| L R B                    | Glossopharyngeal neuralgia (352.1)  |

NOS = Not Otherwise Specified

Continued on next page..

**MEDICAL HISTORY CONTINUED**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Immune system disorder   | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Muscular dystrophy                               | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Shortness of breath                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Injury to                | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Needing extra pillows to help breathing at night | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Sinus problems                        |
| <input type="checkbox"/> Face <input type="checkbox"/> Mouth  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Nervous system irritability                      | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Skin disorder                         |
| <input type="checkbox"/> Neck <input type="checkbox"/> Teeth  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Nervousness                                      | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Slow healing sores                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Insomnia                 | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Neuralgia  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Speech difficulties                   |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Intestinal disorders     | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Osteoarthritis                                   | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Stroke                                |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Jaw joint surgery        | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Osteoporosis                                     | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Swollen, stiff or painful joints      |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Kidney problems          | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Ovarian cysts                                    | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Tendency for:                         |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Liver disease            | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Parkinson's disease                              | <input type="checkbox"/> Frequent Colds  |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Meniere's disease        | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Poor circulation                                 | <input type="checkbox"/> Ear Infections  |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Menstrual cramps         | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Prior orthodontic treatment                      | <input type="checkbox"/> Sore Throats  |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Multiple sclerosis       | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Psychiatric care                                 | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Tired muscles                         |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Muscle aches             | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Radiation treatment                              | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Tuberculosis                          |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Muscle shaking (tremors) | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Rheumatic fever                                  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Tumors                                |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Muscle spasms or cramps  | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Rheumatoid arthritis                             | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Urinary disorders                     |
|   | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Scarlet fever                                    | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Wisdom teeth (Third Molar) extraction |

Other \_\_\_\_\_

**SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN**

L= Left R=Right B=Both sides

HEAD PAIN	LOCATION	SEVERITY			FREQUENCY			DURATION					
		MILD	MODERATE		OCCASIONAL (MONTHLY OR LESS)	FREQUENT (WEEKLY)	CONSTANT (EVERY DAY)	SECONDS	MINUTES	HOURS	DAYS	WEEKS	
				SEVERE									
L R B	Front of your head (Frontal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Entire head (Generalized)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Top of your head (Parietal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Back of your head (Occipital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	In your temples (Temporal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**JAW PAIN**

- L R B Jaw pain - on opening  
 L R B Jaw pain - while chewing  
 L R B Jaw pain - at rest

**JAW SYMPTOMS**

- Y  N  Jaw clicks  
 Y  N  Jaw locks closed  
 Y  N  Jaw locks open  
 Y  N  Jaw popping  
 Y  N  Teeth clenching  
 Y  N  Teeth grinding

**EYE RELATED CONDITIONS**

- Y  N  Blurred vision  
 Y  N  Double vision  
 Y  N  Eye pain  
 Y  N  Pain or pressure behind the eyes  
 Y  N  Photophobia (extreme sensitivity to light)

**EAR RELATED CONDITIONS**

- Y  N  Buzzing in the ears  
 Y  N  Ear congestion  
 Y  N  Ear pain  
 Y  N  Hearing loss  
 Y  N  Pain behind the ear  
 Y  N  Pain in front of the ear  
 Y  N  Recurrent ear infections  
 Y  N  Tinnitus (ringing in the ear)

**THROAT NECK & BACK RELATED CONDITIONS**

- Y  N  Back pain - lower  
 Y  N  Back pain - middle  
 Y  N  Back pain - upper  
 Y  N  Chronic sore throat  
 Y  N  Constant feeling of a foreign object in throat  
 Y  N  Difficulty in swallowing  
 Y  N  Limited movement of neck  
 Y  N  Neck pain  
 Y  N  Numbness in the hands or fingers

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**THROAT NECK & BACK RELATED CONDITIONS (Continued)**

- Y  N  Sciatica
- Y  N  Scoliosis
- Y  N  Shoulder pain
- Y  N  Shoulder stiffness
- Y  N  Swelling in the neck
- Y  N  Swollen glands
- Y  N  Thyroid enlargement
- Y  N  Tightness in throat
- Y  N  Tingling in the hands or fingers
- Y  N  Torticollis

**MOUTH & NOSE RELATED CONDITIONS**

- Y  N  Broken teeth
- Y  N  Burning tongue
- Y  N  Chronic sinusitis
- Y  N  Dry mouth
- Y  N  Frequent biting of cheek
- Y  N  Frequent snoring

Other \_\_\_\_\_

**HISTORY OF SYMPTOMS**

When did your condition first occur? \_\_\_\_\_

What do you believe is the cause of your pain or condition?

*Pick one:*

- Motor vehicle accident
- Motorcycle accident
- Work related incident
- Playground incident
- Athletic endeavor
- Fight
- Fall
- Accident
- Illness
- Injury
- Unknown
- Other \_\_\_\_\_

If accident, date \_\_\_\_\_

Is there anything that makes your pain or discomfort worse? \_\_\_\_\_

Is there anything that makes your pain or discomfort better? \_\_\_\_\_

What other information is important to your pain or condition? \_\_\_\_\_

**FAMILY HISTORY**

Have any members of your family (blood kin) had: Y  N  Headaches      Y  N  High blood pressure  
 Y  N  Heart disease      Y  N  Diabetes

**SOCIAL HISTORY**

Occupation \_\_\_\_\_

Do you have children? Y  N  If yes, how many children? \_\_\_\_\_ What are their ages? \_\_\_\_\_

Y  N  Are you currently under unusual stress?

Y  N  Do you chew tobacco?

Y  N  Recent change in lifestyle?

Number of caffeine drinks per day \_\_\_\_\_

Y  N  Do you exercise regularly?

Y  N  Do you smoke?

\_\_\_\_\_ Number of  Packs  Cigarettes per  Day  Week

*Alcohol consumption*

None       Social Drinker  
 Occasional       Daily

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:**

MILD PAIN



- B Burning
- D Dull
- N Numbing
- P Pressure
- S Sharp
- T Tingling
- R Radiating

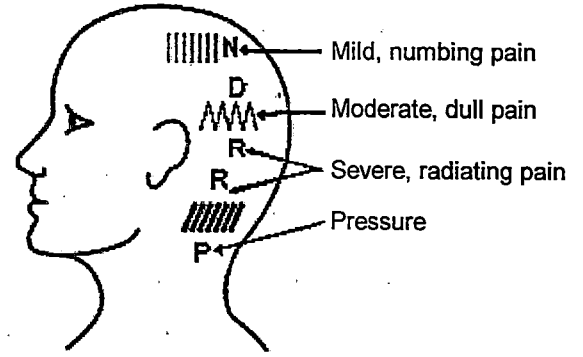
MODERATE PAIN



SEVERE PAIN

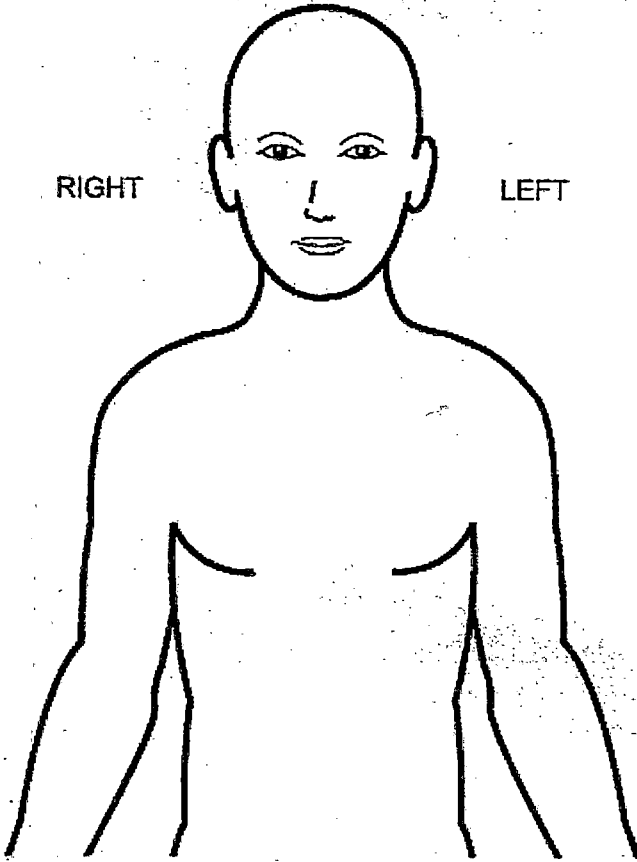


**EXAMPLE**



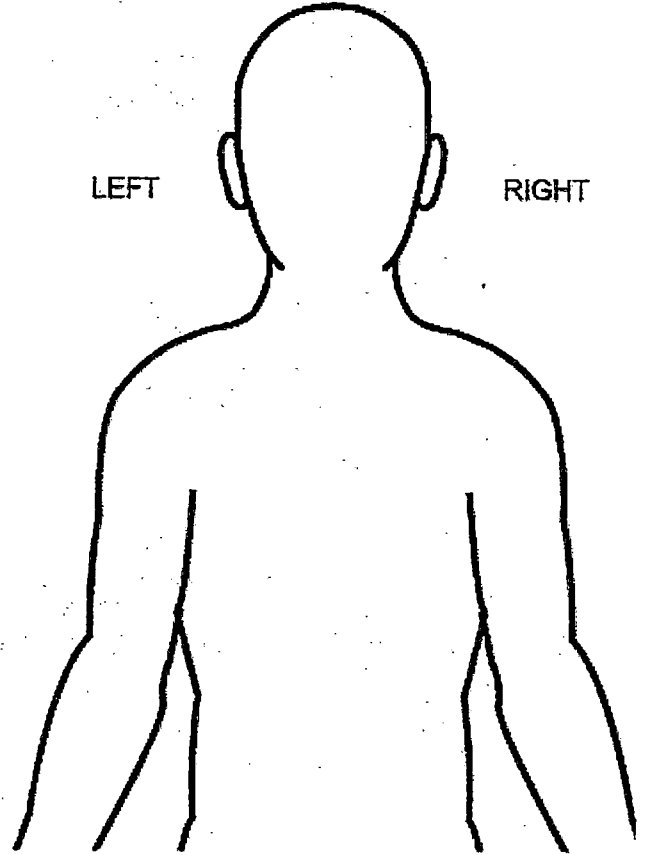
RIGHT

LEFT

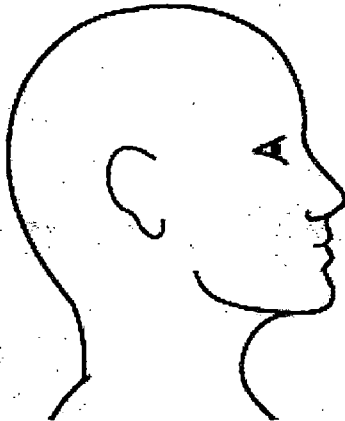


LEFT

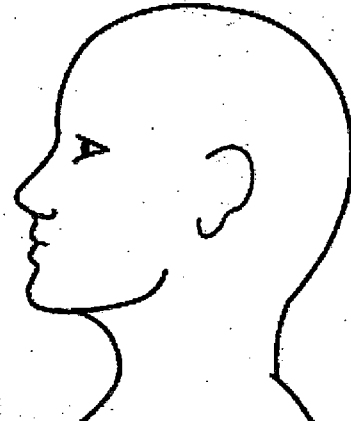
RIGHT



RIGHT



LEFT



Patient Signature \_\_\_\_\_

Date \_\_\_\_\_