

Head, Neck and Facial Pain Questionnaire

| |
|---------------------------------|
| OFFICE USE Patient ID: _____ |
|---------------------------------|

NAME: _____
First Middle Initial Last

TODAY'S DATE _____

DATE OF BIRTH: _____ MALE FEMALE

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

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

2. Then rate your complaints for frequency and intensity:

Frequency

1-SELDOM 2-OCCASIONAL 3-FREQUENT
4-EVERYDAY

Intensity

0=NO PAIN and 10 is MOST SEVERE PAIN

| Number | Frequency | Intensity |
|--------------------------------|-----------|-----------|
| #1 = the most severe symptom | 1-4 | 1-10 |
| _____ TMD / PAIN COMPLAINTS | _____ | _____ |
| _____ Difficulty Swallowing | _____ | _____ |
| _____ Dizziness | _____ | _____ |
| _____ Facial Pain | _____ | _____ |
| _____ Headaches | _____ | _____ |
| _____ Jaw Clicking | _____ | _____ |
| _____ Jaw Locking | _____ | _____ |
| _____ Jaw Pain | _____ | _____ |
| _____ Limited Mouth Opening | _____ | _____ |
| _____ Migraines | _____ | _____ |
| _____ Morning Head Pain | _____ | _____ |
| _____ Morning Hoarseness | _____ | _____ |
| _____ Neck Pain | _____ | _____ |
| _____ Nocturnal Teeth Grinding | _____ | _____ |
| _____ Pain when Chewing | _____ | _____ |
| <i>Other - Write in:</i> | | |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| Number | Frequency | Intensity |
|--|-----------|-----------|
| #1 = the most severe symptom | 1-4 | 1-10 |
| _____ Ringing in the Ears | _____ | _____ |
| _____ SLEEP BREATHING COMPLAINTS | _____ | _____ |
| _____ CPAP Intolerance | _____ | _____ |
| _____ Difficulty Falling Asleep | _____ | _____ |
| _____ Fatigue | _____ | _____ |
| _____ Frequent Heavy Snoring | _____ | _____ |
| _____ Frequent Heavy Snoring Which Affects the Sleep of Others | _____ | _____ |
| _____ Gasping when Waking Up | _____ | _____ |
| _____ Nighttime Choking Spells | _____ | _____ |
| _____ Significant Daytime Drowsiness | _____ | _____ |
| _____ Sleepy while Driving | _____ | _____ |
| _____ Witnessed Apneic Events | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Patient Signature _____

Date _____

Symptoms

HEAD PAIN
Alternative Place for LOCATION on the PAIN Hx TAB
__Yes __No Entire head (Generalized)

[L] [R] [B] Front of your head (Frontal)
__Yes __No Top of the head

[L] [R] [B] Back of your head
[L] [R] [B] In your temples

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
__Yes __No Jaw popping
[L] [R] [B] Jaw clicking
__Yes __No Jaw locks closed
__Yes __No Jaw locks open
__Yes __No Teeth grinding

MOUTH AND NOSE RELATED CONDITION
__Yes __No Burning tongue
__Yes __No Frequent biting of cheek
__Yes __No Frequent snoring
__Yes __No Broken teeth
__Yes __No Teeth clenching
__Yes __No Dry mouth

EAR RELATED CONDITIONS
__Yes __No Buzzing in the ears
__Yes __No Tinnitus (ringing in the ears)
__Yes __No Ear pain
__Yes __No Ear congestion
__Yes __No Pain in front of the ear

__Yes __No Hearing loss
__Yes __No Recurrent ear infections
__Yes __No Pain behind the ear

EYE RELATED CONDITIONS
Double Vison, Photophobia in PAIN Hx
__Yes __No Blurred vision
__Yes __No Eye pain
__Yes __No Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITIONS CONTINUED
__Yes __No Back pain - lower
__Yes __No Back pain - middle
__Yes __No Back pain - upper
__Yes __No Chronic sore throat
__Yes __No Constant feeling of a foreign object in throat
__Yes __No Difficulty in swallowing
__Yes __No Limited movement of neck
__Yes __No Neck pain
__Yes __No Numbness in the hands or fingers
__Yes __No Sciatica
__Yes __No Scoliosis
__Yes __No Shoulder pain
__Yes __No Shoulder stiffness
__Yes __No Swelling in the neck
__Yes __No Swollen glands
__Yes __No Thyroid enlargement
__Yes __No Tightness in throat
__Yes __No Tingling in the hands or fingers
__Yes __No Chronic sinusitis

Other _____

HISTORY OF SYMPTOMS

When did your condition first occur? _____

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

- Pick one: Motor vehicle accident Motorcycle accident Work related incident
 Athletic endeavor Fight Playground incident Accident
 Illness Injury Other _____
 Unknown Fall

If accident, enter 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? _____

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

| Practioner | Specialty | Treatment & Approximate date |
|------------|-----------|------------------------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |

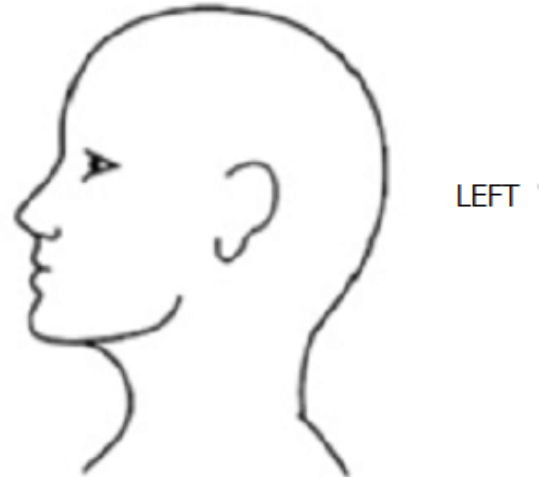
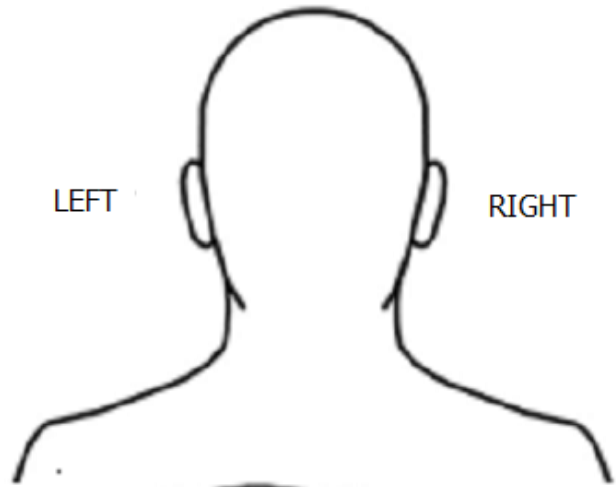
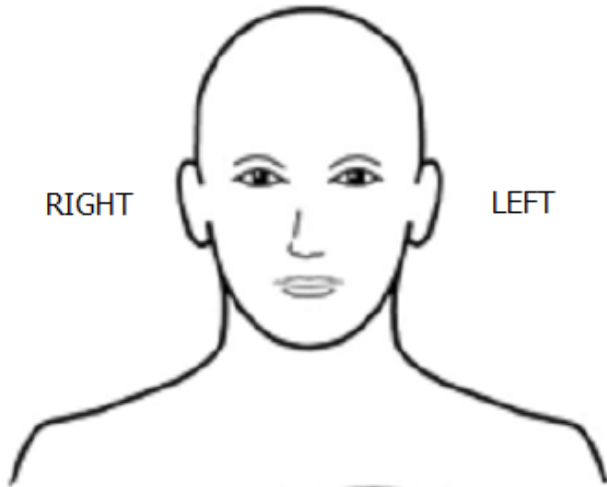
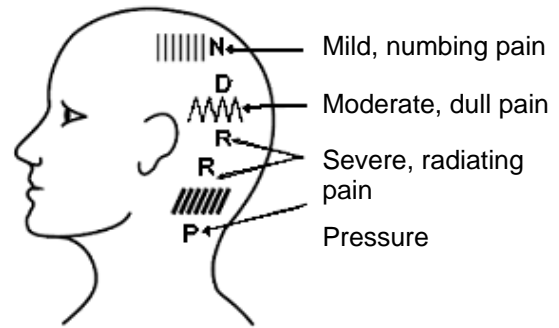
HEAD PAIN HISTORY

| | |
|--|---|
| <p>Pain Qualities</p> <p>_____ --- LOCATION --- _____ Which side are the headaches worse? (Choose ONE from below) _____ both sides _____ the left side _____ the right side _____ Headache spreads to (Choose ONE from below) _____ the temple _____ the back of the head _____ the forehead --- SEVERITY ON A SCALE OF 0-10 --- --- 0=No Pain 10=Worst Pain Imaginable --- _____ Jaw Pain on a Numeric Pain Scale _____ Headaches on a 0-10 Pain Scale _____ Neck Pain on a Numeric Pain Scale _____ Facial Pain on a 0-10 Pain Scale _____ FREQUENCY (Choose ONE from below) --- DURATION --- ___Yes ___No Seconds ___Yes ___No Minutes ___Yes ___No Hours ___Yes ___No Days ___Yes ___No Weeks</p> | <p>When having pain do you experience:</p> <p>___Yes ___No Dizziness ___Yes ___No Double vision ___Yes ___No Fatigue ___Yes ___No Nausea ___Yes ___No Sensitivity to light (photophobia) ___Yes ___No Sensitivity to noise ___Yes ___No Throbbing ___Yes ___No Vomiting ___Yes ___No Burning</p> |
|--|---|

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

- | | | |
|---------------|---------|--------------------|
| MILD PAIN | | B Burning |
| | | D Dull |
| | | N Numbing |
| MODERATE PAIN | ~~~~~ | P Pressure |
| | | S Sharp |
| SEVERE PAIN | /////// | T Tingling |
| | | R Radiating |



I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

I certify that the medical history information is complete and accurate.

Patient Signature _____ Date _____