Head, Neck and Facial Pain Questionnaire

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 and determining the source of your problem. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION

TODAY'S DATE: _____ LAST NAME: _____ MIDDLE INITIAL

FIRST NAME: _____ DR / MR/ MRS /MS: _____

ADDRESS: _____

AGE: _____ DATE OF BIRTH: _____ Male___ Female___

RACE: Optional For Statistical Purposes Only ____ Asian ____ Black ____Caucasian ____ Hispanic ____ Native American

EMAIL: _____

INSURANCE CLAIM NUMBER: _____ SS#: _____

HOME TELEPHONE: _____ BUSINESS TELEPHONE: _____

FAMILY PHYSICIAN: _____ ADDRESS: _____

FAMILY DENTIST: _____ ADDRESS: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?
(In order of importance with 1 being most important.)

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9 _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

LIST ANY MEDICATIONS WHICH HAVE CAUSED AN ALLERGIC REACTION.

_____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

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

Practitioner	Specialty	Treatment & approx. date
1.		
2.		
3.		
4.		
5.		
6.		

_____ _____

Patient Signature Date

MEDICAL HISTORY

PLEASE CHECK THE FOLLOWING CONDITIONS WHICH APPLY TO YOUR MEDICAL HISTORY.

ALLERGIES:
- ☐ Hay fever
- ☐ Food Allergies: _____
- ☐ Allergic to:

_____

_____

ARTHRITIS:
- ☐ Gout
- ☐ Osteoarthritis Specify location: _____
- ☐ Rheumatoid arthritis
- ☐ Other: _____

ENDOCRINE DISORDERS:
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Parathyroid disease
- ☐ Thyroid disease
- ☐ Other: _____

EYE DISORDERS:
- ☐ Glaucoma
- ☐ Occular herpes
- ☐ Other: _____

HIV ORDERS:
- ☐ Tested HIV positive
- ☐ AIDS
- ☐ Other: _____

KIDNEY / URINARY DISORDERS:
- ☐ Bladder infections
- ☐ Blood in urine
- ☐ Kidney disease
- ☐ Sugar in urine
- ☐ Other: _____

MUSCLE DISORDERS:
- ☐ Muscular dystrophy
- ☐ Muscle shaking (tremors)
- ☐ Muscle spasms or cramps
- ☐ Other: _____

NERVE DISORDERS:
- ☐ Cerebral palsy
- ☐ Epilepsy
- ☐ Neuralgia
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Stroke
- ☐ Other: _____

ARTIFICIAL IMPLANTS:
- ☐ Heart pacemaker
- ☐ Heart valve
- ☐ Joint replacement
  Specify joint and side: _____
- ☐ Other: _____

BLOOD DISORDERS:
- ☐ Anemia
- ☐ Bleeding easily
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Sickle cell anemia
- ☐ Other: _____

HEART / CIRCULATORY DISORDERS:
- ☐ Arteriosclerosis
- ☐ Congenital heart disorders (at birth)
- ☐ Coronary artery disease
- ☐ Heart murmur
- ☐ Heart palpitations
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rheumatic fever
- ☐ Other: _____

LIVER DISEASE:
- ☐ Cirrhosis of the liver
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Other: _____

LUNG / RESPIRATORY DISORDERS:
- ☐ Asthma
- ☐ Chronic colds
- ☐ Emphysema
- ☐ Frequent cough
- ☐ Lung cancer
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ Other: _____

STOMACH / INTESTINAL DISORDERS:
- ☐ Bloating
- ☐ Colitis
- ☐ Constipation
- ☐ Frequent diarrhea
- ☐ Frequent gas
- ☐ Gallbladder problems
- ☐ Heartburn
- ☐ Poor digestion
- ☐ Ulcers
- ☐ Other: _____

_____
Patient Signature

_____
Date

OTHER CONDITIONS:

- ☐ Bruising easily
- ☐ Chemotherapy
- ☐ Chronic fatigue
- ☐ Cold hands and feet
- ☐ Depression
- ☐ Dizziness
- ☐ Excessive thirst
- ☐ Fluid retention
- ☐ Frequent stressful situations
- ☐ Frequently ill
- ☐ Frequently irritable
- ☐ History of alcohol abuse
- ☐ History of substance abuse
- ☐ Insomnia
- ☐ Nervousness
- ☐ Osteoporosis
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Scarlet fever
- ☐ Skin condition
- ☐ Slow healing sores
- ☐ Swollen, stiff or painful joints
- ☐ Tired Muscles
- ☐ Trouble concentrating
- ☐ Tumors
- ☐ Use extra pillows to help breathing
- ☐ Yeast infections
- ☐ Other: _____

Women:

- ☐ Currently pregnant
- ☐ Menstrual cramps
- ☐ Ovarian cysts

SYMPTOMS

CHECK THE SYMPTOMS WHICH APPLY TO YOUR CONDITION.

HEAD PAIN

LOCATION				SEVERITY			FREQUENCY			DURATION				
				Mild	Moderate	Severe	Occasional	Frequent	Constant	Seconds	Minutes	Hours	Days	Weeks
L	R	B	(L: Left, R: Right, B: Both Sides)											
☐	☐	☐	Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	Facial	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

JAW RELATED CONDITIONS:

JAW PAIN:

L	R	B	(Left, Right, Both Sides)
☐	☐	☐	On opening
☐	☐	☐	On wide opening
☐	☐	☐	On side to side movement
☐	☐	☐	On closing
☐	☐	☐	While chewing
☐	☐	☐	At rest (without provocation)
		☐	Other: _____
		☐	Clench teeth
		☐	Grind teeth

- ☐ Jaw pops
- ☐ Jaw clicks when opening mouth
- ☐ Jaw clicks when closing mouth
- ☐ Jaw goes to left when opening
- ☐ Jaw goes to right when opening
- ☐ Jaw locks closed
- ☐ Jaw locks open
- ☐ Inability to move jaw to left
- ☐ Inability to move jaw to right
- ☐ Other: _____

EYE RELATED CONDITIONS:

- ☐ Blurred vision
- ☐ Double vision
- ☐ Lacrimation (excessive watering)
- ☐ Opthalmic migraine
- ☐ Pain in the eyes
- ☐ Pain or pressure behind the eyes
- ☐ Photophobia (extreme sensitivity to light)
- ☐ Swelling below the eyes
- ☐ Other: _____

EAR RELATED CONDITIONS:

- ☐ Buzzing in the ears
- ☐ Congestion/stuffiness
- ☐ Dizziness
- ☐ Earache
- ☐ Excessive wax production
- ☐ Hearing loss
- ☐ Itching in the ears
- ☐ Menieres disease
- ☐ Pain deep inside ear
- ☐ Pain in front of ear
- ☐ Pain behind ear
- ☐ Recurrent infections
- ☐ Tinnitus (ringing or roaring in the ear)
- ☐ Other: _____

_____ _____

Patient Signature Date

NECK AND BACK RELATED CONDITIONS:

- ☐ Back pain (lower)
- ☐ Back pain (middle)
- ☐ Back pain (upper)
- ☐ Back pain radiating to the neck
- ☐ Constant feeling of foreign object in throat
- ☐ Shoulder pain
- ☐ Tightness in throat
- ☐ Neck pain
- ☐ Limited movement of neck
- ☐ Stiffness in neck
- ☐ Numbness or tingling in the hands or fingers
- ☐ Constant sore throat
- ☐ Difficulty in swallowing
- ☐ Scoliosis
- ☐ Sciatica
- ☐ Swelling in the neck
- ☐ Swollen glands
- ☐ Swollen lymph nodes
- ☐ Thyroid enlargement
- ☐ Wryneck
- ☐ Other: _____

MOUTH AND NOSE RELATED CONDITIONS:

- ☐ Broken teeth
- ☐ Burning tongue
- ☐ Chronic sinusitis
- ☐ Dry mouth
- ☐ Frequent biting of cheek
- ☐ Had orthodontics
- ☐ Have had general anesthesia
- ☐ Sensitive or sore teeth
- ☐ Tendency to snore
- ☐ Wisdom teeth removed (date) _____
- ☐ Other: _____

OTHER CONDITIONS:

- ☐ Currently under unusual stress
- ☐ Recent change in lifestyle
- ☐ Recent change in work pattern

SYMPTOMS ARE WORSE:

- ☐ Upon arising in morning
- ☐ At end of day
- ☐ At work
- ☐ At school
- ☐ At home
- ☐ When under stress
- ☐ Other: _____

WHAT MAKES YOUR PAIN WORSE? _____

WHAT HELPS YOUR CONDITION? _____

WHEN DID YOUR CONDITION FIRST OCCUR? _____

WHAT DO YOU BELIEVE IS THE CAUSE OF YOUR PAIN OR CONDITION?

- ☐ A motor vehicle accident (Date:_____)
- ☐ A motorcycle accident (Date:_____)
- ☐ A work-related incident (Date:_____)
- ☐ Playground incident (Date:_____)
- ☐ Athletic endeavor ☐ Fight ☐ Fall (Date:_____)
- ☐ Unknown (Date:_____)
- ☐ Other: _____

WHAT OTHER INFORMATION IS IMPORTANT TO YOUR CONDITION? _____

_____

_____

_____ _____

Patient Signature Date

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

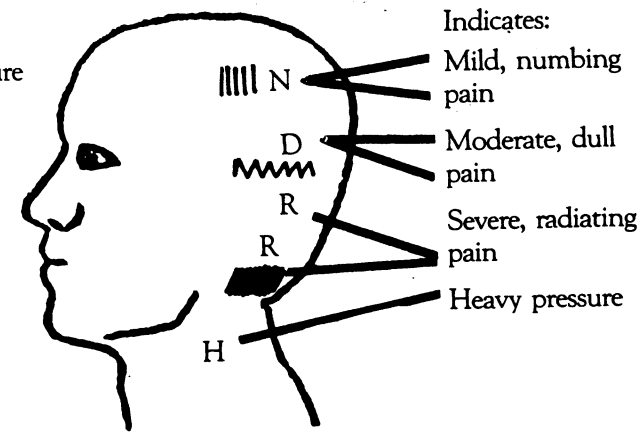
MILD PAIN

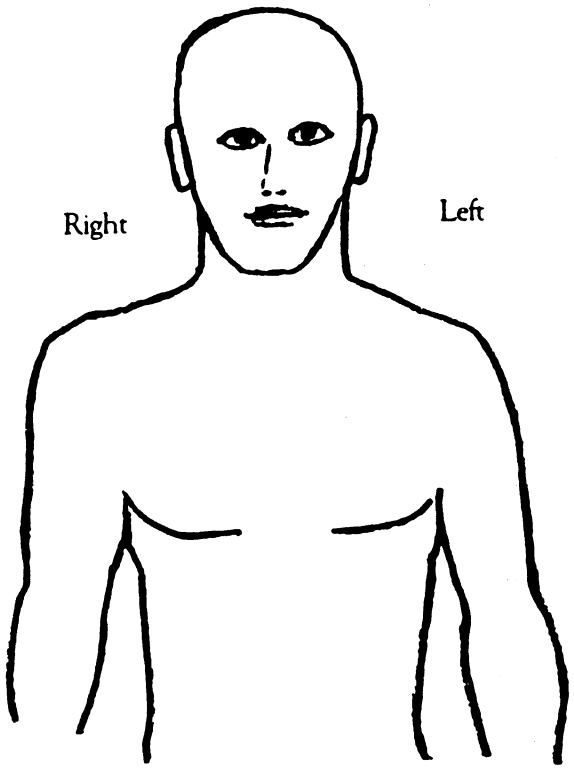
MODERATE PAIN

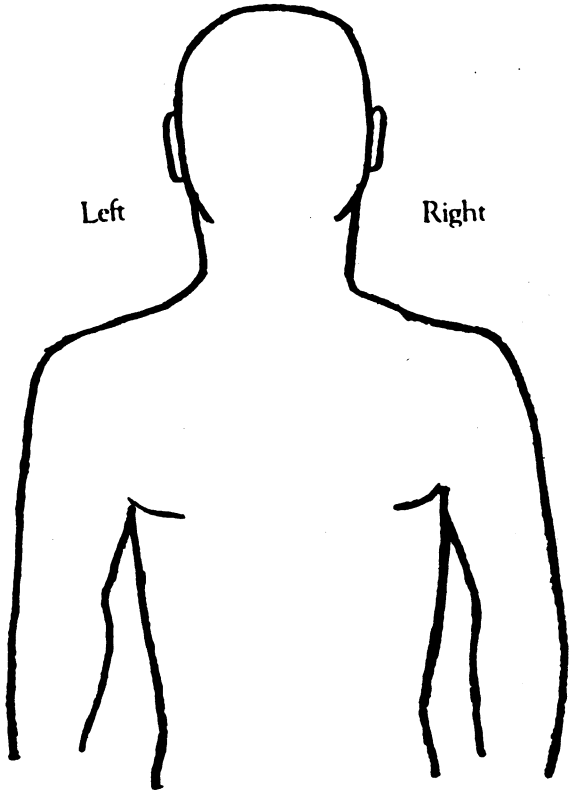
SEVERE PAIN

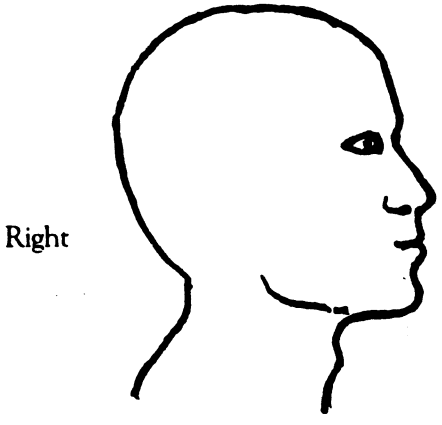
B Burning
D Dull
H Heavy Pressure
N Numbing
S Sharp
T Tingling
R Radiating

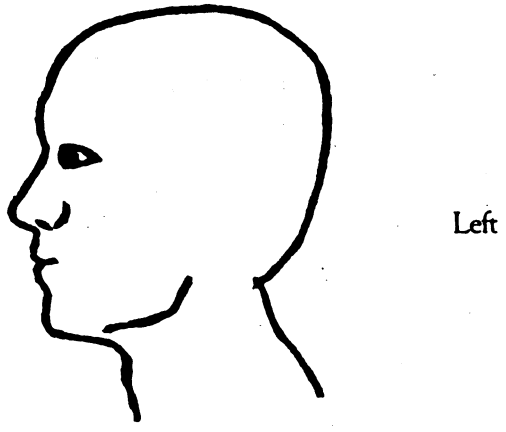
EXAMPLE:











Patient Signature

Date

ACCIDENT INFORMATION

IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT, COMPLETE THIS SECTION.

DATE OF ACCIDENT OR INCIDENT: _____

WERE YOU?

- ☐ A passenger in a vehicle
- ☐ The driver of a vehicle
- ☐ A pedestrian
- ☐ At work

- ☐ Did you fall?
- ☐ Were you hit by an object?
- ☐ Did you hit an object?
- ☐ Other: _____

IF IN A VEHICLE WHERE WAS THE VEHICLE HIT?

- ☐ At front end
- ☐ At rear end
- ☐ At front right area
- ☐ At front left area
- ☐ At rear right area
- ☐ At rear left area

- ☐ Head on
- ☐ On driver's side
- ☐ On passenger's side
- ☐ Other: _____

INDICATE IF THERE WAS ANY DIRECT TRAUMA.

DID YOUR

- ☐ Forehead
- ☐ Face
- ☐ Chin
- ☐ Side of head
- ☐ Back of head
- ☐ Top of head
- ☐ Teeth
- ☐ Jaw
- ☐ Other: _____

FORCIBLY STRIKE

- ☐ Steering wheel
- ☐ Windshield
- ☐ Passenger's side window
- ☐ Driver's side window
- ☐ Passenger's side door
- ☐ Driver's side door
- ☐ Headrest
- ☐ Seat
- ☐ Roof
- ☐ Other: _____

WERE ANY AREAS OF YOUR BODY PAINFUL SHORTLY AFTER THE ACCIDENT/INCIDENT?

- ☐ Head
- ☐ Neck
- ☐ Face
- ☐ Jaw
- ☐ Left shoulder
- ☐ Right shoulder

- ☐ Left arm
- ☐ Right arm
- ☐ Lower back
- ☐ Upper back
- ☐ Other: _____

BRIEFLY DESCRIBE THE ACCIDENT OR INCIDENT:

_____

DID YOU GO TO THE HOSPITAL? ☐ Yes ☐ No By car? ☐ By ambulance? ☐

IF TAKEN TO THE HOSPITAL FOR X-RAYS & EVALUATION

WERE YOU ☐ SUBSEQUENTLY RELEASED ON _____ (Date)

☐ CONFINED OVERNIGHT _____ (Date)

WHICH HOSPITAL? _____ IF CONFINED.

HAS A DOCTOR OR DENTIST EVER DIAGNOSED A TMJ DISORDER PRIOR TO THE ACCIDENT?

☐ Yes ☐ No If yes, please explain _____

_____

_____ _____

Patient Signature Date

IF YOU HAD A PREVIOUS ACCIDENT, PLEASE GIVE AN ACCURATE DESCRIPTION, INCLUDING

_____

DATE: _____

_____

NAMES AND ADDRESSES OF HOSPITALS AND DOCTORS WHERE TREATED FOR THIS PREVIOUS ACCIDENT:

_____

_____

IF YOU HAVE MISSED ANY WORK PLEASE GIVE DATES: _____

INSURANCE INFORMATION

PIP-AUTO INSURANCE

Please mark each insurance category

☐ your insurance ☐ driver of vehicle's insurance ☐ other vehicle's insurance ☐ owner of vehicle's insurance

Insured _____ Insured's Soc. Sec. No. _____ Relationship _____

Insured's Address _____ City & State _____ Zip Code _____

Insurance Co. _____ Adjuster (not agent) _____ Phone No. _____

Insurance Billing Address _____ City & State _____ Zip Code _____

Policy No. _____ Claim No. _____ Has this been reported? _____

If you have additional automobile insurance, please enter the information on the reverse side of this form.

OTHER TYPES OF INSURANCE

HEALTH INSURANCE (Complete even if you are covered by auto insurance)

Insured _____ Insured's Soc. Sec. No. _____ Relationship _____

Insured's Employer and Address _____

Address _____ City & State _____ Zip Code _____

Insurance Co. _____ Adjuster (not agent) _____ Phone No. _____

Insurance Billing Address _____ City & State _____ Zip Code _____

Policy No. _____ Group No. _____ I.D. No. _____

WORKER'S COMPENSATION

Employee _____

Address _____ City & State _____ Zip Code _____

Employer _____ Phone No. _____ Supervisor _____

Has this been reported? _____ If yes, was treatment authorized? _____

Insurance Co. _____ Adjuster _____ Phone No. _____

Insurance Billing Address _____ City & State _____ Zip Code _____

Claim No. _____

_____ _____

Patient Signature Date

ATTORNEY INFORMATION

If you have an attorney representing you, please complete the following:

Attorney's Name _____ Para Legal _____ Phone No. _____

Address _____ City & State _____ Zip Code _____

Are you negotiating a settlement regarding the accident? _____

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.

Signed _____

FOR OFFICE USE ONLY

Contact Person _____ Phone No. _____ Today's Date _____

Effective date of this policy _____ TMJ policy _____

Amount of deductible _____ Has it been satisfied? _____

Amount of benefits _____ How much used? _____

Billing address _____ City & State _____ Zip Code _____

Adjuster _____ Assignment approved _____ by _____

Other: _____

_____ _____

Patient Signature Date