

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	_____	_____
_____	Ringling in the Ears	_____	_____
_____	Shoulder Pain	_____	_____
_____	Sinus Congestion	_____	_____
_____	Throat Pain	_____	_____
_____	Visual Disturbances	_____	_____
_____	Other - write in:	_____	_____
_____		_____	_____
_____		_____	_____

Patient Signature _____

Date _____

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"/> Fluid retention | 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"/> Frequent cough | Y <input type="checkbox"/> N <input type="checkbox"/> Heart valve replacement |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chemotherapy | Y <input type="checkbox"/> N <input type="checkbox"/> Frequent illnesses | 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 stressful situations | 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"/> Fibromyalgia | Y <input type="checkbox"/> N <input type="checkbox"/> Hypoglycemia |

Patient Signature _____ Date _____

MEDICAL HISTORY CONTINUED

- Y N Immune system disorder
- Y N Injury to
 - Face Mouth
 - Neck Teeth
- Y N Insomnia
- Y N Intestinal disorders
- Y N Jaw joint surgery
- Y N Kidney problems
- Y N Liver disease
- Y N Meniere's disease
- Y N Menstrual cramps
- Y N Multiple sclerosis
- Y N Muscle aches
- Y N Muscle shaking (tremors)
- Y N Muscle spasms or cramps

- Y N Muscular dystrophy
- Y N Needing extra pillows to help breathing at night
- Y N Nervous system irritability
- Y N Nervousness
- Y N Neuralgia
- Y N Osteoarthritis
- Y N Osteoporosis
- Y N Ovarian cysts
- Y N Parkinson's disease
- Y N Poor circulation
- Y N Prior orthodontic treatment
- Y N Psychiatric care
- Y N Radiation treatment
- Y N Rheumatic fever
- Y N Rheumatoid arthritis
- Y N Scarlet fever

- Y N Shortness of breath
- Y N Sinus problems
- Y N Skin disorder
- Y N Slow healing sores
- Y N Speech difficulties
- Y N Stroke
- Y N Swollen, stiff or painful joints
- Y N Tendency for:
 - Frequent Colds
 - Ear Infections
 - Sore Throats
- Y N Tired muscles
- Y N Tuberculosis
- Y N Tumors
- Y N Urinary disorders
- Y N 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"/>
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"/>
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"/>
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"/>
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"/>

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:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> Motorcycle accident | <input type="checkbox"/> Work related incident | <input type="checkbox"/> Playground incident |
| <input type="checkbox"/> Athletic endeavor | <input type="checkbox"/> Fight | <input type="checkbox"/> Fall | <input type="checkbox"/> Accident |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Illness | <input type="checkbox"/> Injury |

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 Day
 Cigarettes per Week

Alcohol consumption

None Social Drinker
 Occasional Daily

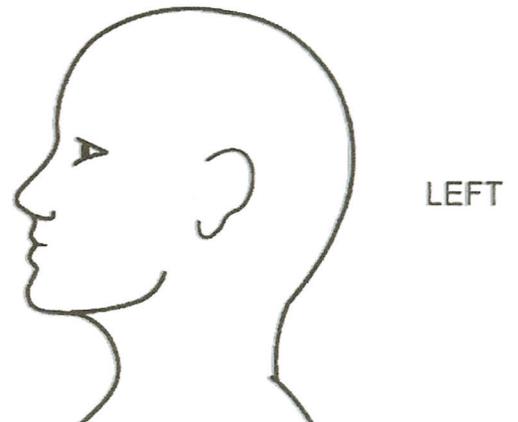
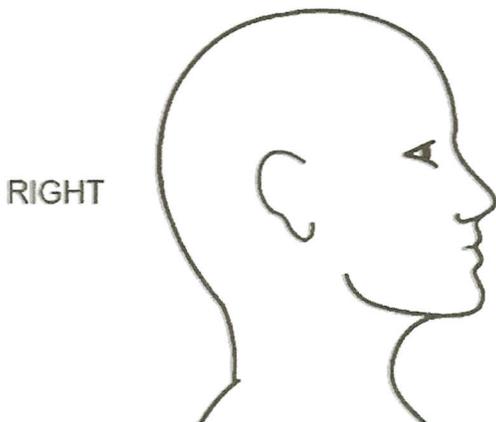
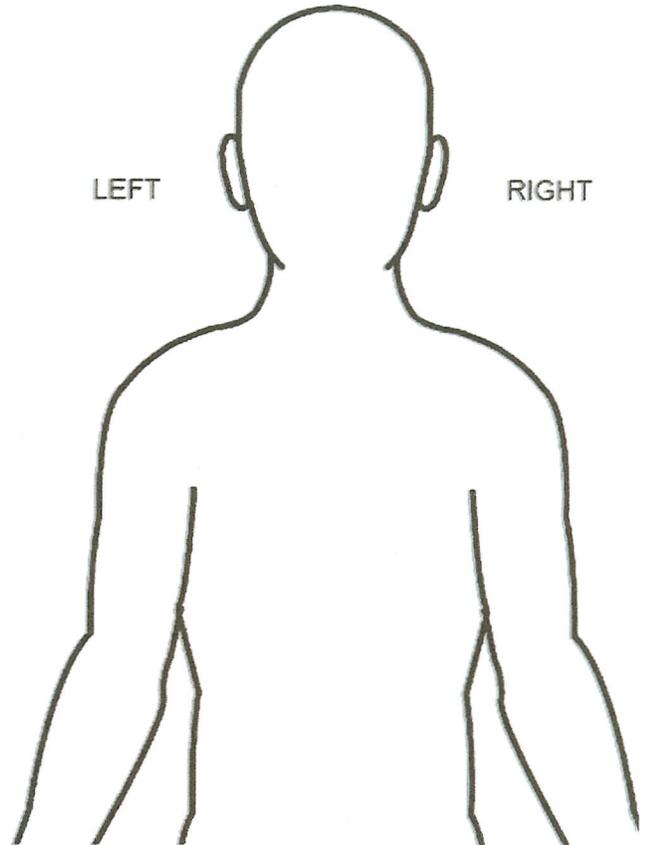
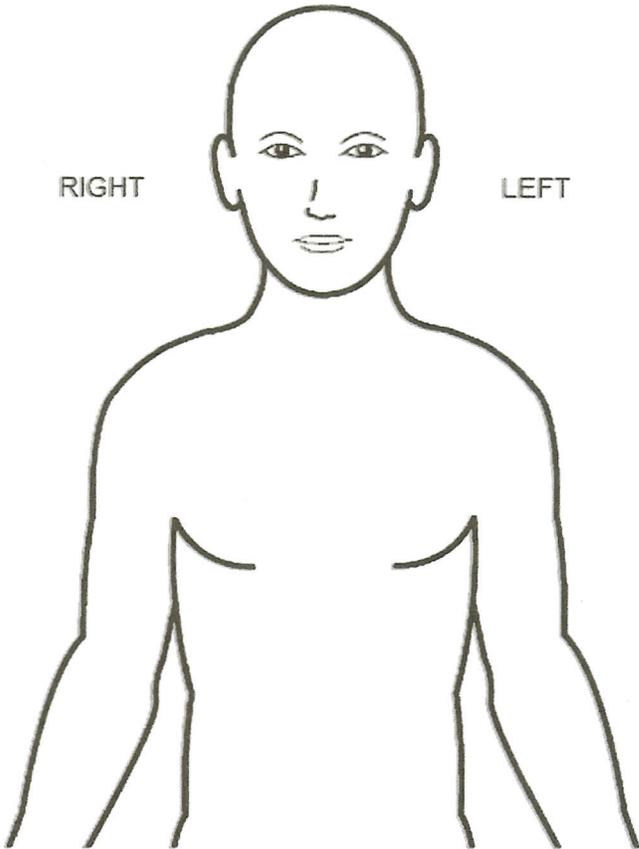
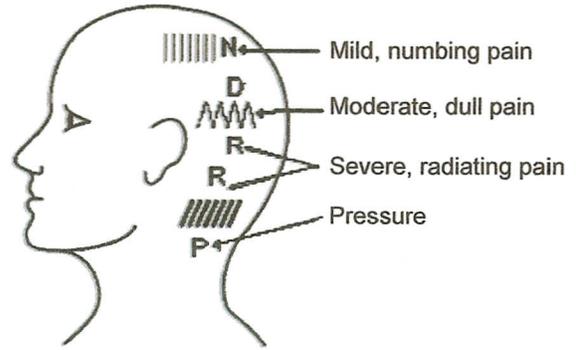
Patient Signature _____

Date _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

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

EXAMPLE



Patient Signature _____

Date _____

HISTORY OF ACCIDENT

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

DATE OF ACCIDENT OR INCIDENT _____

WERE YOU ?

(Choose one)

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

AND...

(Choose one)

- 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
- Interior of car
- 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 HISTORY OF SYMPTOMS, ACCIDENT OR INCIDENT: _____

DID YOU GO TO THE HOSPITAL? Yes No By Car By Ambulance

TAKEN TO THE HOSPITAL FOR X-RAYS & EVALUATION

WERE YOU SUBSEQUENTLY RELEASED ON (Date) _____

WHICH HOSPITAL? _____

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

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 Birth date. _____

Insured's Address _____

City, State, Zip _____

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

Insurance Billing Address _____

City, State, Zip _____

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

OTHER TYPES OF INSURANCE

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

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

Relationship _____ Insured's Birth date. _____

Insured's Address _____

City, State, Zip _____

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

Insurance Billing Address _____

City, State, Zip _____

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

WORKER'S COMPENSATION

Employee _____

Address _____

City, State, Zip _____

Employer _____ Phone No. _____ Supervisor _____

Has this been reported? Yes No If yes, was treatment authorized? _____

Insurance Co. _____

Insurance Billing Address _____

City, State, Zip _____

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

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

Patient Signature _____ Date _____