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:		
___	_____	___	___
___	_____	___	___

Patient Signature

_____

Date _____

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

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Other _____ _____
_____ _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Barbiturates
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Nerve pills
Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ 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☐ N☐ Adenoids Removed
Y☐ N☐ Tonsils Removed
Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Blood pressure ☐High ☐Low
Y☐ N☐ Bruising easily
Y☐ N☐ Cancer
Y☐ N☐ Chemotherapy
Y☐ N☐ Chronic fatigue
Y☐ N☐ Cold hands & feet
Y☐ N☐ Current pregnancy
Y☐ N☐ Depression
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Excessive thirst
Y☐ N☐ Fluid retention
Y☐ N☐ Frequent cough
Y☐ N☐ Frequent illnesses
Y☐ N☐ Frequent stressful situations
Y☐ N☐ Fibromyalgia
Y☐ N☐ General anesthesia
Y☐ N☐ Glaucoma
Y☐ N☐ Gout
Y☐ N☐ Hay fever
Y☐ N☐ Hearing impairment
Y☐ N☐ Heart murmur
Y☐ N☐ Heart disorder
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart palpitations
Y☐ N☐ Heart valve replacement
Y☐ N☐ Hemophilia
Y☐ N☐ Hepatitis
Y☐ N☐ 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	SEVERE	OCCASIONAL (MONTHLY OR LESS)	FREQUENT (WEEKLY)	CONSTANT (EVERY DAY)	SECONDS	MINUTES	HOURS	DAYS	WEEKS
L R B Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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☐ Wryneck

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☐ Recent change in lifestyle?
Y☐ N☐ Do you exercise regularly?

Y☐ N☐ Do you chew tobacco?

Number of caffeine drinks per day _____

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:

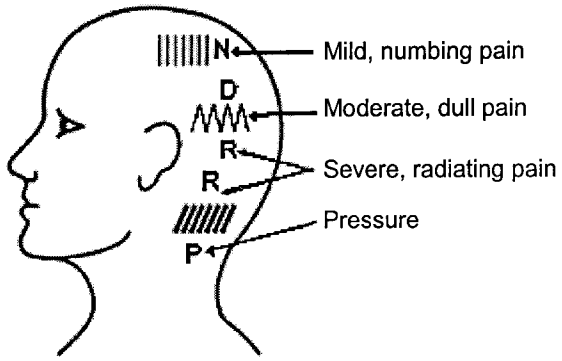
MILD PAIN

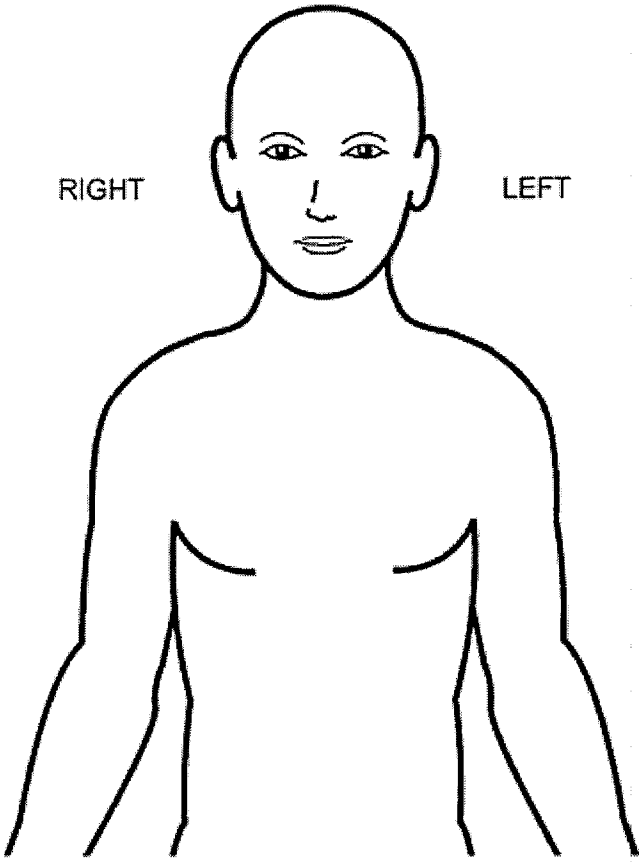
MODERATE PAIN

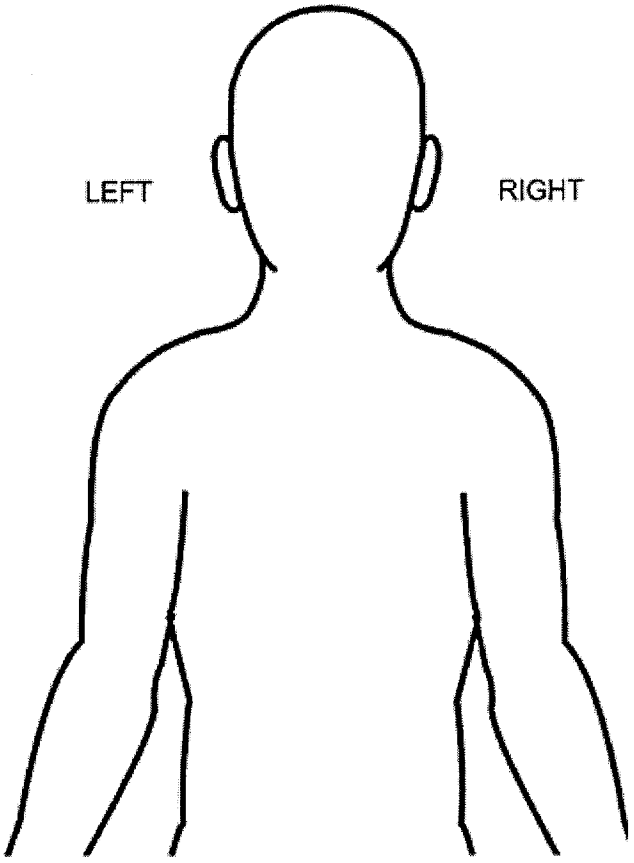
SEVERE PAIN

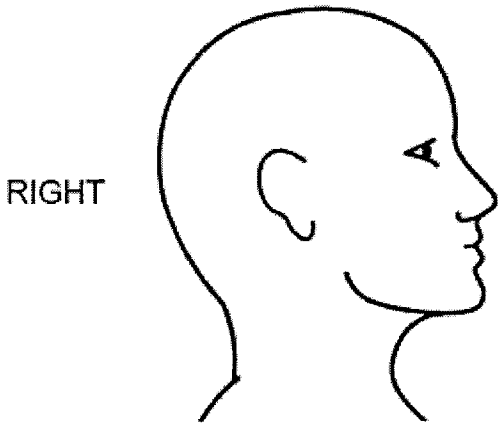
B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

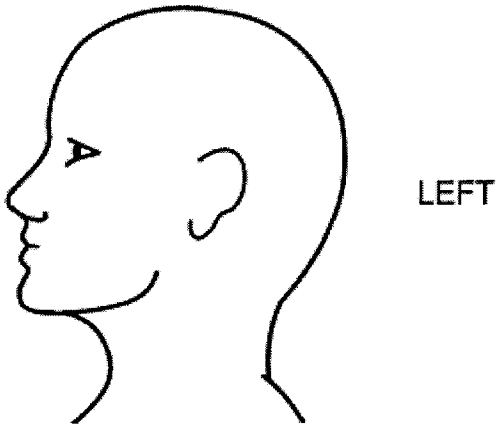
EXAMPLE











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? _____

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

☐ Yes ☐ No If yes, please explain _____

_____

Patient Signature _____ Date _____