

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: _____

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:

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)

Patient Signature _____

Date _____

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

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

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

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

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

Patient Signature _____ Date _____

MEDICAL HISTORY CONTINUED

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

- | | | | |
|-------------------------------------------------|----------------------------------------------|------------------------------------------------|----------------------------------------------|
| <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 <input type="checkbox"/> N <input type="checkbox"/> Do you smoke? _____ Number of <input type="checkbox"/> Packs <input type="checkbox"/> Day <input type="checkbox"/> Cigarettes per <input type="checkbox"/> Week

Alcohol consumption <input type="checkbox"/> None <input type="checkbox"/> Social Drinker <input type="checkbox"/> Occasional <input type="checkbox"/> Daily

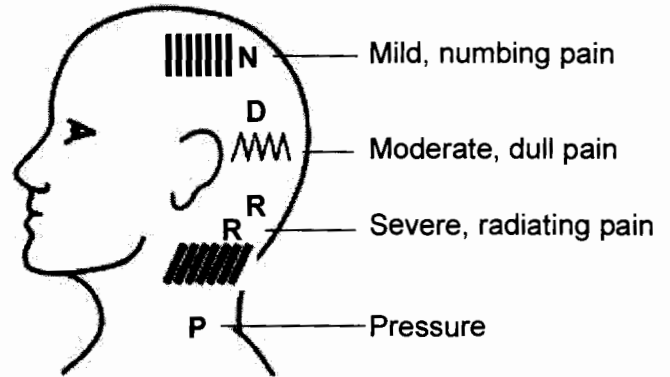
Patient Signature _____

Date _____

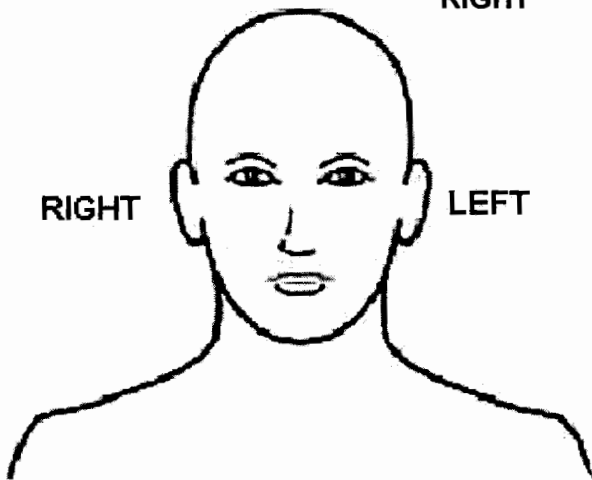
DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

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

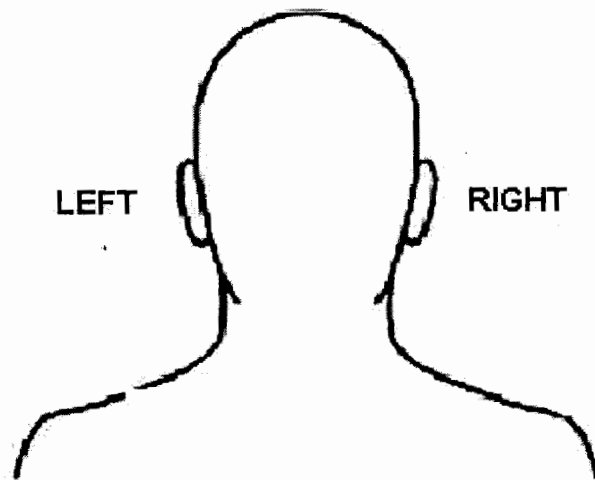
EXAMPLE



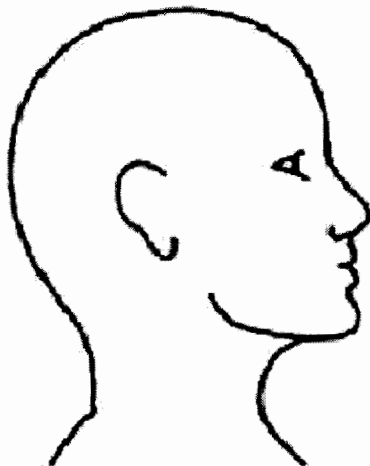
RIGHT



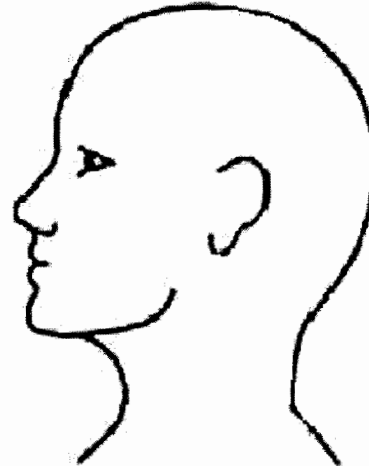
LEFT



RIGHT



LEFT



Patient Signature _____

ADVANCED CENTER for TMJ, FACIAL PAIN and SLEEP DISORDERS

Throat, Mouth and Jaw Posture and Muscle Function Disorders

Hitesh K. Patel, D.D.S., F.I.C.C.M.O
1060 E. Ogden Ave
Naperville, IL 60563
630-305-7500

FREQUENT HEAD/FACIAL SYMPTOMS

Many symptoms may be associated with jaw problems. Body systems are inter-related and cannot be separated. The following is a list of symptoms that are frequently managed with the services provided by TMJ Associates. Please indicate by circling which of these are of concern to you, without regard to their possible origin. You may also add any other symptoms. Thank you.

PAIN PROBLEMS

1. Head Pain
2. Neck Pain
3. Facial Pain
4. Ear (dizziness, stuffiness, etc.)
5. Other

PROBLEMS WITH JAW USE

1. Difficulty Eating
2. Difficulty Speaking
3. Limited opening, Locking
4. Other

APPEARANCE

1. Poor Posture
2. Dark Circles Under Eyes
3. Tired Appearance
4. Weight Concerns

STRESS FEELINGS

1. Fight or flight feeling (panic attacks)
2. Feeling "Driven", Always Thinking
3. Feeling restless when laying down
4. Other

SNORING

1. Loud
2. Concern to Others
3. Awaken yourself, snorts, gasps
4. Startled Awakening, Rapid heart rate

POOR SLEEP

1. Tired in the day, low energy level
2. Restless sleep
3. Nighttime or Morning Pain

OTHER

SIGNED _____

DATE _____

Diplomat of American Academy of Pain Management, Fellow of International College of Cranio-Mandibular Orthopedics Fellow Academy of Dentistry International, Fellow American College of Forensic Examiners, American Academy of Craniofacial Pain, American Academy of Dental Sleep Medicine, American Dental Association, Chicago Dental Society, Illinois State Dental Society, Academy of General Dentistry, Associate Member of the Cranial Academy