

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

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Y ☐ N ☐ Antibiotics	Y ☐ N ☐ Cortisone	Y ☐ N ☐ Nerve pills
Y ☐ N ☐ Anticoagulants	Y ☐ N ☐ Diet pills	Y ☐ N ☐ Pain medication
Y ☐ N ☐ Barbiturates	Y ☐ N ☐ Heart medication	Y ☐ N ☐ Sleeping pills
Y ☐ N ☐ Blood thinners	Y ☐ N ☐ Insulin	Y ☐ N ☐ Sulfa drugs
Y ☐ N ☐ Codeine	Y ☐ N ☐ Muscle relaxants	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 ☐ Current pregnancy	Y ☐ N ☐ General anesthesia
Y ☐ N ☐ Tonsils Removed	Y ☐ N ☐ Depression	Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Anemia	Y ☐ N ☐ Diabetes	Y ☐ N ☐ Gout
Y ☐ N ☐ Arteriosclerosis	Y ☐ N ☐ Difficulty concentrating	Y ☐ N ☐ Hay fever
Y ☐ N ☐ Asthma	Y ☐ N ☐ Dizziness	Y ☐ N ☐ Hearing impairment
Y ☐ N ☐ Autoimmune disorders	Y ☐ N ☐ Emphysema	Y ☐ N ☐ Heart murmur
Y ☐ N ☐ Bleeding easily	Y ☐ N ☐ Epilepsy	Y ☐ N ☐ Heart disorder
Y ☐ N ☐ Blood pressure ☐ High ☐ Low	Y ☐ N ☐ Excessive thirst	Y ☐ N ☐ Heart pacemaker
Y ☐ N ☐ Bruising easily	Y ☐ N ☐ Fibromyalgia	Y ☐ N ☐ Heart palpitations
Y ☐ N ☐ Cancer	Y ☐ N ☐ Fluid retention	Y ☐ N ☐ Heart valve replacement
Y ☐ N ☐ Chemotherapy	Y ☐ N ☐ Frequent cough	Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Chronic fatigue	Y ☐ N ☐ Frequent illnesses	Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Cold hands & feet	Y ☐ N ☐ Frequent stressful situations	Y ☐ N ☐ Hypoglycemia

Patient Signature _____ Date _____

MEDICAL HISTORY CONTINUED

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

<u>HEAD PAIN</u>		<u>LOCATION</u>	<u>SEVERITY</u>			<u>FREQUENCY</u>			<u>DURATION</u>						
			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 ☐ 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:

- ☐ 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 ☐ 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

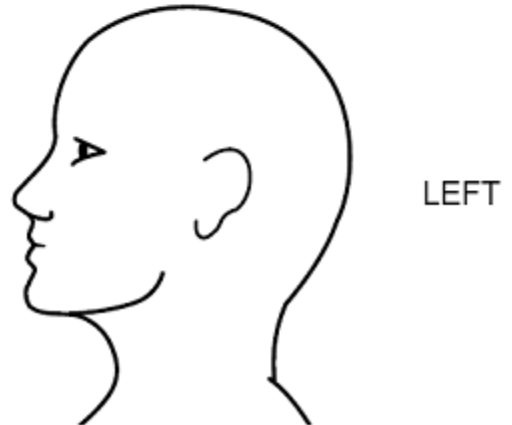
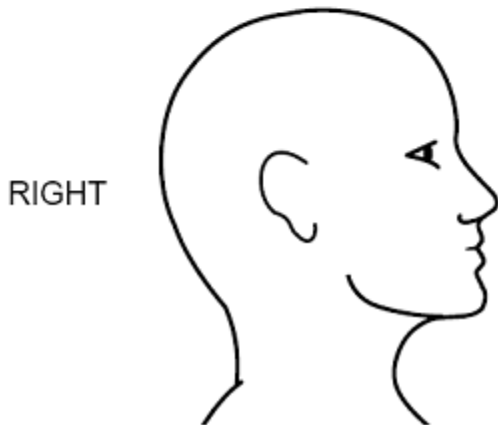
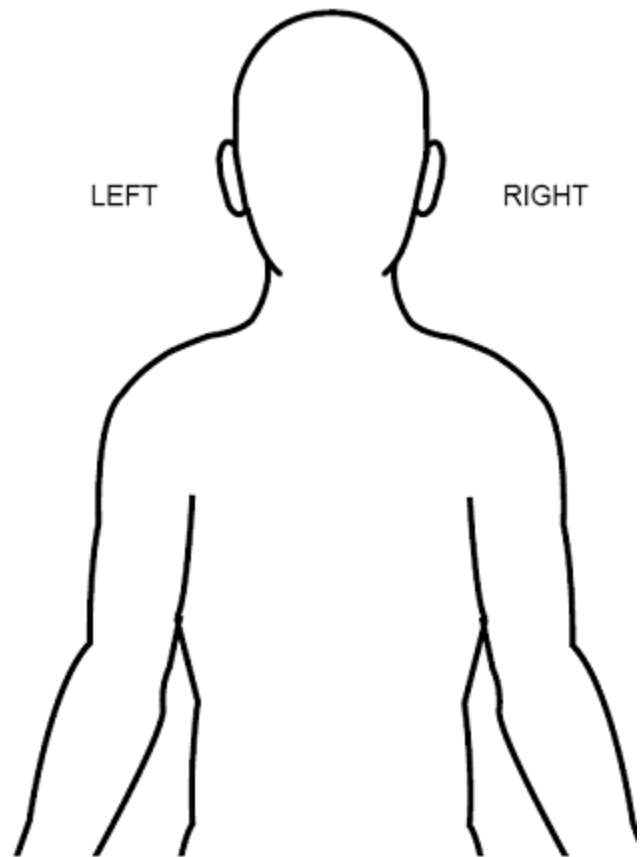
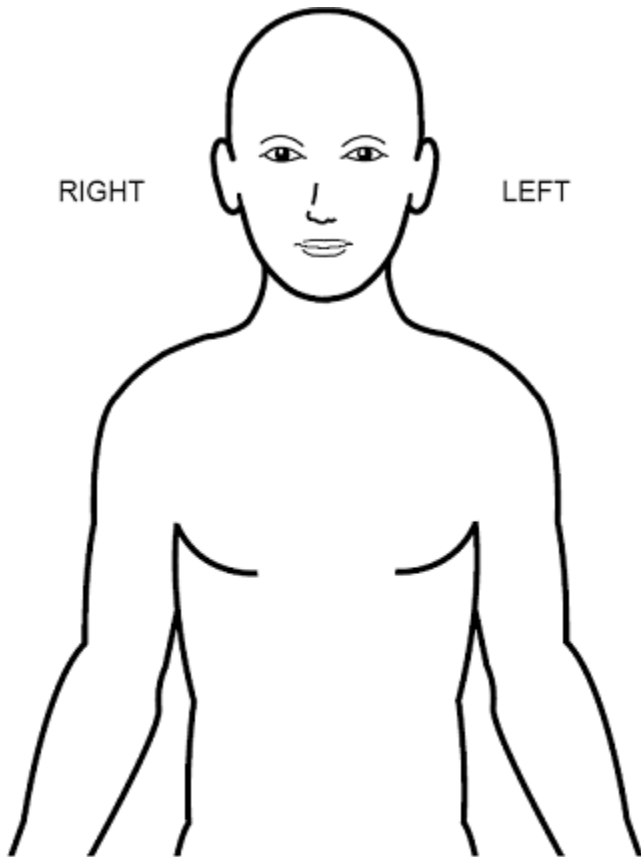
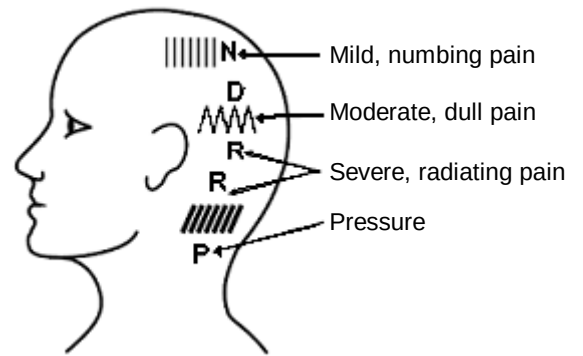
- ☐ None ☐ Social Drinker
☐ Occasional ☐ Daily

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

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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 _____

ATTORNEY INFORMATION

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

Attorney's Name _____ Paralegal _____ Phone No. _____

Address _____

City, State, Zip _____

Are you involved in a lawsuit regarding your condition? ☐ Yes ☐ No

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 _____

FOR OFFICE USE ONLY

Insurance Company _____

☐ Group Health ☐ Auto ☐ Government ☐ Self Insured ☐ Dental

Contact Person _____

Effective date of this policy, _____ TMJ policy exclusions _____

Amount of deductible? _____ Has it been satisfied? _____

At what percentage are benefits paid? _____

Is there a policy maximum for TMJ disorders? _____

Is precertification required _____

Can benefits be assigned to doctor? ☐ Yes ☐ No

What information is needed to process the claim? _____

For No Fault: Amount of benefits _____

Mailing Address _____

City, State, Zip _____

Adjuster _____ Assignment approved ☐ Yes ☐ No

By _____

Other: _____

Patient Signature _____ Date _____