

Today's Date: _____

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

Mr. Ms. Miss Mrs. Dr.
 Male Female

Name: _____

Age: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Employed By: _____

Address: _____

SS#: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Responsible Party: _____

Physician Name & 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	___	___
___ Jaw Clicking	___	___
___ Jaw Joint Noises	___	___
___ Jaw Locking	___	___
___ Jaw Pain	___	___
___ Limited Mouth Opening	___	___
___ Muscle Soreness	___	___
___ Muscle Twitching	___	___
___ Neck Pain	___	___
___ Pain when Chewing	___	___
___ Ringing in the Ears	___	___
___ Shoulder Pain	___	___
___ Sinus Congestion	___	___
___ Throat Pain	___	___
___ Visual Disturbances	___	___
___ Other: _____	___	___

LIST ANY MEDICATIONS WHICH HAVE CAUSED AN ALLERGIC REACTION

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

Other allergens:

Patient Signature: _____ Date: _____

"If excellence is available,
GOOD IS NOT ENOUGH"

Today's Date: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Y	N	Antibiotics	Y	N	Heart medication	Other Current Medications: _____ _____ _____
Y	N	Anticoagulants	Y	N	Insulin	
Y	N	Blood thinners	Y	N	Muscle relaxants	
Y	N	Codeine	Y	N	Pain medications	
Y	N	Cortisone	Y	N	Sleeping pills	
Y	N	Diet pills	Y	N	Sulfa drugs	

MEDICAL HISTORY

Y	N	Anemia	Y	N	Hearing impairment	Y	N	Osteoarthritis
Y	N	Arteriosclerosis	Y	N	Heart murmur	Y	N	Osteoporosis
Y	N	Asthma	Y	N	Heart disorder	Y	N	Poor circulation
Y	N	Autoimmune disorders	Y	N	Heart pacemaker	Y	N	Prior orthodontic treatment
Y	N	Bleeding easily	Y	N	Heart valve replacement	Y	N	Radiation treatment
Y	N	Blood pressure <input type="checkbox"/> High <input type="checkbox"/> Low	Y	N	Hemophilia	Y	N	Rheumatic fever
Y	N	Cancer	Y	N	Hepatitis	Y	N	Scarlet fever
Y	N	Chemotherapy	Y	N	Immune system disorder	Y	N	Shortness of breath
Y	N	Chronic fatigue	Y	N	Injury to <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Teeth <input type="checkbox"/> Head <input type="checkbox"/> Mouth	Y	N	Sinus problems
Y	N	Current pregnancy				Y	N	Sleep Apnea
Y	N	Diabetes	Y	N	Insomnia	Y	N	Speech difficulties
Y	N	Difficulty concentrating	Y	N	Intestinal disorders	Y	N	Swollen, stiff or painful joints
Y	N	Dizziness	Y	N	Jaw joint surgery	Y	N	Teeth clenching or grinding
Y	N	Emphysema	Y	N	Meniere's disease	Y	N	Wisdom teeth extraction
Y	N	Epilepsy	Y	N	Migraines	Other Medical History: _____ _____ _____		
Y	N	Fibromyalgia	Y	N	Multiple sclerosis			
Y	N	Frequent snoring	Y	N	Muscle Spasms or cramps			
Y	N	Hay fever	Y	N	Needing extra pillows to help breath at night			

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)	<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 (Paietal)	<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"/>

HISTORY OF SYMPTOMS

When did your condition first occur? (month-day-year): _____

What do you believe to be the the cause of your pain or condition: _____

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

If accident, what was the date?: _____

What other information is important to your pain or condition: _____

Patient Signature: _____ Date: _____

"If excellence is available, GOOD IS NOT ENOUGH"