DENTA4

Form I - Head, Neck, Facial Pain & TMJ Questionnaire

Assistant/Doctor Form | Phone: 1 (604) - 777 - 1337

This form is to be filled out by the Doctor or Staff.

This questionnaire is designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis to aid in determining the source of your problem. Please take your time and answer each question as completely and honestly as possible.

Patient Information and History

Name | Age | Birthrate | Todays date | Sex: ☐ Male ☐ Female

Address | City | State | Zip

Home phone | Work phone | SS# | Occupation

Marital Status | Spouse | Number of children | Drivers License Number

Dental Insurance

Insurance company | Policy holder | Group number

Employer | Effective date

Medical Insurance

Insurance company | Policy holder | Group number

Employer | Effective date

Other information

How did you hear about our office?

Who referred you to this practice?

Why are you seeking this consultation?

Any history of TMJ treatment?

☐ Yes ☐ No

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Orofacial History

Please check if you have had or have now any of the following for each area

Head

Forehead headaches	☐ Past	☐ Now
Temporal headaches	☐ Past	☐ Now
Tension headaches	☐ Past	☐ Now
Migraine headaches	☐ Past	☐ Now
Sinus headaches	☐ Past	☐ Now
Back of head tenderness	☐ Past	☐ Now
Scalp tender to touch	☐ Past	☐ Now

Ear

Earache without infection	☐ Past	☐ Now		
Loss of hearing	☐ Past	☐ Now	☐ Right	☐ Left
Ringing/Buzzing	☐ Past	☐ Now	☐ Right	☐ Left
Stuffy/Itchy	☐ Past	☐ Now	☐ Right	☐ Left
Dizziness/Vertigo	☐ Past	☐ Now	☐ Right	☐ Left
Balance problems	☐ Past	☐ Now	☐ Right	☐ Left
Pain in front	☐ Past	☐ Now	☐ Right	☐ Left
Pain behind	☐ Past	☐ Now	☐ Right	☐ Left

Throat

Swallowing difficulties	☐ Past	☐ Now
Foreign object feeling	☐ Past	☐ Now
Sore throat without infection	☐ Past	☐ Now
Frequent clearing or coughing	☐ Past	☐ Now
Voice changes	☐ Past	☐ Now

Mouth – Teeth

Missing teeth	☐ Past	☐ Now
Caps or Crowns	☐ Past	☐ Now
Partials or dentures	☐ Past	☐ Now
Teeth ground on	☐ Past	☐ Now
Teeth grinding	☐ Past	☐ Now
Need dental work	☐ Past	☐ Now
Loose teeth	☐ Past	☐ Now
Broken teeth	☐ Past	☐ Now
Sensitive teeth	☐ Past	☐ Now
Crowded teeth	☐ Past	☐ Now

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Dry mouth	☐ Past	☐ Now
Bad Bite	☐ Past	☐ Now
Can't find bite	☐ Past	☐ Now
Clench or grind teeth	☐ Past	☐ Now
Gum disease	☐ Past	☐ Now
Had orthodontics	☐ Past	☐ Now
Year		
General appearance/smile	☐ Past	☐ Now
Overall function	☐ Past	☐ Now

Other comments:

Posture

Flat feet	☐ Past	☐ Now
Pain to sit	☐ Past	☐ Now
Pain to stand	☐ Past	☐ Now
Rolled shoulders	☐ Past	☐ Now
Shoulder pain	☐ Past	☐ Now
Shoulder stiffness	☐ Past	☐ Now
Scoliosis	☐ Past	☐ Now
Cross legs often	☐ Past	☐ Now
Low back pain	☐ Past	☐ Now
Bump into walls	☐ Past	☐ Now
Drift when walking	☐ Past	☐ Now
Dizziness	☐ Past	☐ Now
Tingling in hands or fingers	☐ Past	☐ Now

Nasal – Sinus

Allergies	☐ Past	☐ Now		
Sinus pain	☐ Past	☐ Now	☐ Right	☐ Left
Sinus surgery	☐ Past	☐ Now		
Chronic infections	☐ Past	☐ Now		
Difficult nasal breathing	☐ Past	☐ Now		
Post nasal drainage	☐ Past	☐ Now		

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Eye

Pain in/around eyes	☐ Past	☐ Now		
Sensitive to sunlight	☐ Past	☐ Now		
Pressure behind eye	☐ Past	☐ Now		
Tearing	☐ Past	☐ Now		
Blurred vision	☐ Past	☐ Now		
Loss of vision	☐ Past	☐ Now	☐ Right	☐ Left

Neck

Neck pain	☐ Past	☐ Now		
Shoulder pain	☐ Past	☐ Now		
Lack of mobility	☐ Past	☐ Now		
Cervical collar use	☐ Past	☐ Now		
Nasal – Sinus	☐ Past	☐ Now		
Arm pain/numbness	☐ Past	☐ Now		
Finger pain/numbness	☐ Past	☐ Now		
Shoulder pain	☐ Past	☐ Now		

Back

Lower back pain	☐ Past	☐ Now		
Mid back pain	☐ Past	☐ Now		
Upper back pain	☐ Past	☐ Now		
Sciatica	☐ Past	☐ Now		

TMJ – Jaw

Clicking noise	☐ Past	☐ Now	☐ Right	☐ Left
Grinding noise	☐ Past	☐ Now	☐ Right	☐ Left
Jaw/cheek pain	☐ Past	☐ Now	☐ Right	☐ Left
Jaw joint pain	☐ Past	☐ Now	☐ Right	☐ Left
Restricted opening	☐ Past	☐ Now		
Uneven opening	☐ Past	☐ Now		
Locks open	☐ Past	☐ Now		
Jaw deviation to side	☐ Past	☐ Now		
Pain to move	☐ Past	☐ Now	☐ Right	☐ Left
Pain at rest	☐ Past	☐ Now	☐ Right	☐ Left
Jaw trauma	☐ Past	☐ Now		

General anesthesia	☐ Past	☐ Now		
Chewing difficulty	☐ Past	☐ Now		
Jaw locks closed	☐ Past	☐ Now		
Jaw locks opened	☐ Past	☐ Now		
Jaw pain when chewing	☐ Past	☐ Now		
Ringing in the ear	☐ Past	☐ Now	☐ Right	☐ Left
Pain behind the ear	☐ Past	☐ Now	☐ Right	☐ Left
Pain in front of the ear	☐ Past	☐ Now	☐ Right	☐ Left

Sleep

Difficulty waking	☐ Past	☐ Now
Difficulty falling asleep	☐ Past	☐ Now
Snore (heavy)	☐ Past	☐ Now
Frequent awakening (tossing and turning)	☐ Past	☐ Now
Morning drowsiness	☐ Past	☐ Now
Sleep apnea	☐ Past	☐ Now
Daytime fatigue	☐ Past	☐ Now
Nighttime gasping	☐ Past	☐ Now
Hours of Sleep/night:	☐ Past	☐ Now
Kicking or jerking leg repeatedly	☐ Past	☐ Now
Swelling in ankles or feet	☐ Past	☐ Now
Morning hoarseness	☐ Past	☐ Now
Feeling unrefreshed in morning	☐ Past	☐ Now
Told that "I stop breathing during sleep"	☐ Past	☐ Now

What are your chief complaints (main concerns) listing the most important first?

Doctor Note

This form is to be filled out by the Doctor or Staff.

Personal Physician:

Clinic:

Address:

Date of last complete physical

Telephone:

Are you under care of a physician currently?

☐ Yes ☐ No

Why?

Hospitalized within the last five years?

☐ Yes ☐ No

Why?

Surgeries: Please list and provide year of surgery. Include surgeries for craniofacial pain issues and sleep disorders.

Surgery	Year

This form is to be filled out by the Doctor or Staff.

Allergies

List any allergies you may have or substances that caused an allergic reaction:

List any medications you are taking:

Medication	Reason
Medication	Reason
Medication	Reason
Medication	Reason
Medication	Reason
Medication	Reason
Medication	Reason
Medication	Reason
Medication	Reason

List any vitamins, herbs, home remedies etc. You are taking or using:

Vitamins, herbs, home remedies etc.	Reason
Vitamins, herbs, home remedies etc.	Reason
Vitamins, herbs, home remedies etc.	Reason
Vitamins, herbs, home remedies etc.	Reason
Vitamins, herbs, home remedies etc.	Reason
Vitamins, herbs, home remedies etc.	Reason

This form is to be filled out by the Doctor or Staff.

List any previous treatment/medications for the condition we are evaluating:

Treatment/Medication	Reason
Treatment/Medication	Reason
Treatment/Medication	Reason
Treatment/Medication	Reason
Treatment/Medication	Reason
Treatment/Medication	Reason
Treatment/Medication	Reason
Treatment/Medication	Reason
Treatment/Medication	Reason

List Doctors/Medical Providers you are currently seeing or have seen in the past:

Doctors/Medical Provider	Reason
Doctors/Medical Provider	Reason
Doctors/Medical Provider	Reason
Doctors/Medical Provider	Reason
Doctors/Medical Provider	Reason
Doctors/Medical Provider	Reason

I release and give my permission for this office to request and communicate with the providers listed above.

Patient Signature

Parent/Guardian Signature

This form is to be filled out by the Doctor or Staff.

Perpetuating Factors

Please check in the appropriate area any lifestyle factors pain factors that may cause or perpetuate chronic pain stages.

Phone cradling	☐ Past	☐ Now
Pipe/cigar/cigarettes	☐ Past	☐ Now
Carry shoulder	☐ Past	☐ Now
Heavy lifting work	☐ Past	☐ Now
Drawing/writing	☐ Past	☐ Now
Keyboard use	☐ Past	☐ Now
Bending over	☐ Past	☐ Now
High heels	☐ Past	☐ Now
On feet all day	☐ Past	☐ Now
Stick shift	☐ Past	☐ Now
Play musical instrument	☐ Past	☐ Now
Wear tight collar	☐ Past	☐ Now
Wear bifocals	☐ Past	☐ Now
Use cane or crutches	☐ Past	☐ Now
Considered suicide	☐ Past	☐ Now
Depressed	☐ Past	☐ Now
Emotional	☐ Past	☐ Now
No regular exercise	☐ Past	☐ Now
Repetitive job	☐ Past	☐ Now
Long drives	☐ Past	☐ Now
Daily drives	☐ Past	☐ Now
Sitting	☐ Past	☐ Now
Arm out car window	☐ Past	☐ Now
Hand on car wheel	☐ Past	☐ Now
Non power steering	☐ Past	☐ Now
Over closed bite	☐ Past	☐ Now
Overweight	☐ Past	☐ Now
Impaired speech Impaired speech	☐ Past	☐ Now
Stomach sleeping	☐ Past	☐ Now
Thick pillow Thick pillow	☐ Past	☐ Now
Solid foam pillow	☐ Past	☐ Now
Uncomfortable chair	☐ Past	☐ Now
Mattress to hard	☐ Past	☐ Now

This form is to be filled out by the Doctor or Staff.

Mattress too hard	☐ Past	☐ Now
Lifting children	☐ Past	☐ Now
Long hair	☐ Past	☐ Now
Lap sewing	☐ Past	☐ Now
Desk with no knee space	☐ Past	☐ Now
Thumb sucker	☐ Past	☐ Now
Pacifier	☐ Past	☐ Now
Mouth breather	☐ Past	☐ Now
Finger nail biter	☐ Past	☐ Now
Pencil chewer	☐ Past	☐ Now
Gum chewer	☐ Past	☐ Now
Ill fitting glasses	☐ Past	☐ Now
Chronic cough	☐ Past	☐ Now
Bronchitis/asthma	☐ Past	☐ Now
One ear deafness	☐ Past	☐ Now
Pain vacuum Pain to vacuum	☐ Past	☐ Now
Carry heavy briefcase	☐ Past	☐ Now
Suitcase carrying	☐ Past	☐ Now
Suitcase carrying	☐ Past	☐ Now
Exposure to cold drafts	☐ Past	☐ Now
Tennis/racquetball	☐ Past	☐ Now
Jogging	☐ Past	☐ Now
Riding horses	☐ Past	☐ Now
Exercise classes	☐ Past	☐ Now
Singing	☐ Past	☐ Now
Yawning	☐ Past	☐ Now
Beautician/hairstylist	☐ Past	☐ Now
Overhead work	☐ Past	☐ Now
Bending forward	☐ Past	☐ Now
Bra strap heavy	☐ Past	☐ Now
Ice chewer Ice chewer	☐ Past	☐ Now
Reading in bed	☐ Past	☐ Now
Recline to watch TV	☐ Past	☐ Now
Poor posture	☐ Past	☐ Now
Poor attitude	☐ Past	☐ Now

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Health And Medical History

Have you experienced an allergic reaction to any of the following:

☐ Anesthesia ☐ Antibiotics, if so, what kind_____ ☐ Aspirin ☐ Codeine ☐ Iodine

☐ Latex ☐ Metals ☐ Penicillin ☐ Sedatives ☐ Sleeping pills ☐ Sulfa

☐ Other, please indicate:

Are you currently pregnant?

☐ Yes ☐ No

Do you drink 4 or more cups of coffee per day?

☐ Yes ☐ No

Do you smoke tobacco?

☐ Yes ☐ No

Do you consume alcohol?

☐ Yes ☐ No

Do you take sedatives?

☐ Yes ☐ No

Have you had prior orthodontic treatments?

☐ Yes ☐ No

Do you have trouble breathing through your nose?

☐ Yes ☐ No

Do you have trouble breathing through your nose?

☐ Yes ☐ No

Have you sustained injury to:

☐ Head ☐ Neck ☐ Face ☐ Teeth ☐ Other

Additional information:

Have you had any of the following:

☐ Tonsils removed ☐ Adenoids removed ☐ General anesthesia ☐ Jaw joint surgery

☐ Wisdom teeth removed ☐ Oral Surgery ☐ Jaw joint surgery

Additional information:

This form is to be filled out by the Doctor or Staff.

Please indicate if you have experienced or are currently experiencing any of the following:

☐ Heart disorder	☐ Heart attack	☐ Mitral valve prolapse	☐ Heart pacemaker	☐ Heart palpitations
☐ Heart valve replacement	☐ Irregular heartbeat	☐ High blood pressure	☐ Low blood pressure	☐ Stroke
☐ Bleed easily	☐ Bruise easily	☐ Aids/HIV	☐ Anemia	☐ Asthma
☐ Birth defects	☐ Diabetes	☐ Cancer	☐ Epilepsy	☐ Emphysema
☐ Glaucoma	☐ Gerd (Acid Reflux)	☐ Hemophilia	☐ Hepatitis	☐ Hypoglycemia
☐ History of substance abuse	☐ Huntington's disease	☐ Kidney disease	☐ Liver disease	☐ Leukemia
☐ Migraines	☐ Meniere's disease	☐ Multiple sclerosis	☐ Muscular dystrophy	☐ Neuralgia
☐ Osteoarthritis	☐ Osteoporosis	☐ Ovarian Cyst	☐ Parkinson's disease	☐ Rheumatic fever
☐ Rheumatoid arthritis	☐ Scarlet fever	☐ Thyroid problem	☐ Tuberculosis	☐ Intestinal disorder
☐ Nervous system disorder	☐ Anxiety	☐ Skin disorder	☐ Urinary tract disorder	☐ Chronic fatigue
☐ Fibromyalgia	☐ Cold hands and feet	☐ Depression	☐ Difficulty concentrating	☐ Difficulty breathing at night
☐ Dizziness	☐ Excessive thirst	☐ Fainting	☐ Fluid retention	☐ Frequent colds/fl u
☐ Frequent cough	☐ Frequent ear infections	☐ Frequent sore throat	☐ Frequent awakening at night	
☐ Hearing impairment	☐ Memory Loss	☐ Hay fever	☐ Insomnia	☐ Muscle aches
☐ Muscle fatigue	☐ Muscle spasms	☐ Muscle tremors	☐ Poor circulation	☐ Psychiatric care
☐ Recent weight gain	☐ Recent weight loss	☐ Sinus problems	☐ Shortness of breath	☐ Slow healing sores
☐ Speech difficulties	☐ Tired muscles	☐ Swollen, stiff or painful joints		

Pain History

Again, main Again, what are your chief complaints (main concerns) list the most important first. (Please include date)

1.

2.

3.

4.

5.

6.

Are you in pain now?

☐ Yes ☐ No

Please rate the severity of you pain from 0 to 10.

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

☐ Worst level ☐ Usual level ☐ Current level

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Description of pain. (Please select closest to the feeling.)

A.	☐ Stabbing	☐ Sharp	☐ Bright	☐ Stimulating	☐ Raw	
B.	☐ Shocking	☐ Piercing	☐ Burning	☐ Electric	☐ Lancinating	
C.	☐ Dull	☐ Aching	☐ Deep	☐ Depressing	☐ Boring	
D.	☐ Pulsating	☐ Throbbing	☐ Nausea/Vomiting/Aura/Dizziness			
E.	☐ Spasm	☐ Tightness	☐ Stiffness	☐ Cramping	☐ Reduced range of movement	

Characteristics of pain. (Please select closest to the feeling.)

A. Pain Primarily

☐ Right sided ☐ Left sided ☐ Both sided ☐ Varies

B. Intensity

☐ Mild ☐ Moderate ☐ Severe ☐ Moderate (Severe)

C. Onset of pain

☐ Gradual ☐ Sudden ☐ Morning ☐ Night

D. Duration of pain

☐ Intermittent ☐ Variable ☐ Constant ☐ Periodically

E. Pattern of pain

☐ Worst at waking ☐ Worst at night ☐ Increases as the day goes on

Number of days per month with	Headache	Neck ache	Tooth ache

How many types of headaches do you have?

Status of pain

☐ Increasing ☐ Decreasing ☐ Unchanged

What do you think is the cause of your condition?

What starts or makes it worse? (Stress, chewing,foods, weather, etc.)

What makes it better? (Rest, medication, treatments,etc.)

Medication taken for this condition

1.

2.

3.

4.

5.

This form is to be filled out by the Doctor or Staff.

Relieved by: (please select closest)

☐ Antihistamines ☐ Antidepressants ☐ Anti-Anxiety ☐ Aspirin/Tylenol ☐ Muscle Relaxers

☐ Codeine/Narcotics ☐ Cardiac/Blood Pressure Meds ☐ Muscle Relaxers

Are you willing to give up your pain?

☐ Yes ☐ No

Are manage Are you willing to do whatever it takes to manage this this condition?

☐ Yes ☐ No

Does this condition interfere with your daily routine or or interfere with the quality of your life?

☐ Yes ☐ No

How?

What do you believe is the cause of your pain condition?

☐ Yes ☐ No

☐ A motor vehicle accident

☐ A motorcycle accident

☐ A work-related accident

☐ Playground accident

☐ Athletic endeavour

☐ Unknown

☐ Other

Please describe where you hurt.

Past treatments for this condition (Please list each)

1.

Doctors name | Treatment | Results

Address | Telephone Number | Last seen

2.

Doctors name | Treatment | Results

Address | Telephone Number | Last seen

This form is to be filled out by the Doctor or Staff.

3.

Doctors name | Treatment | Results

Address | Telephone Number | Last seen

4.

Doctors name | Treatment | Results

Address | Telephone Number | Last seen

5.

Doctors name | Treatment | Results

Address | Telephone Number | Last seen

6.

Doctors name | Treatment | Results

Address | Telephone Number | Last seen

Date of accident(s) or incident(s)

Were you: (Please select where apply)

- [ ] A passenger in a vehicle
- [ ] The driver of a vehicle
- [ ] A pedestrian
- [ ] At work
- [ ] Did you fall?
- [ ] Were you hit by an object?
- [ ] Did you hit an object?
- [ ] Other

This form is to be filled out by the Doctor or Staff.

If in a vehicle, where was the vehicle hit? (Please select if apply)

☐ At front end ☐ At rear end ☐ At front right area ☐ At rear right area

☐ At rear left area ☐ Head on ☐ On driver's side ☐ On passenger's side

☐ Other

Did you wear a seatbelt?

☐ Yes ☐ No

Indicate if there was any direct trauma. (Please select where apply)

To 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 door

☐ Headrest ☐ Seat ☐ Roof ☐ Other

Were any areas of your body painful shortly after the accident/incident?

☐ Head ☐ Neck ☐ Face ☐ Jaw ☐ Left shoulder

☐ Right shoulder ☐ Left arm ☐ Left arm ☐ Right arm ☐ Lower back

☐ Upper back ☐ Other

Did you go to the hospital?

☐ Yes ☐ No

By car or by ambulance

☐ Car ☐ Ambulance

If taken to the hospital for x-rays and evaluation were you

Subsequently on Subsequently released on

Confined overnight

Name of Hospital

Has a doctor or dentist ever diagnosed a TMJ disorder prior to the accident?

☐ Yes ☐ No

If yes, please explain

This form is to be filled out by the Doctor or Staff.

If you had a previous accident, please give an accurate description including date, names and addresses of hospitals, doctors, dentists, therapists,chiropractor, etc. where you were treated.

Date,

Names

Addresses of hospitals

Doctors

Dentists

Therapists

Chiropractor

Attorney Information

Attorney

Firm

Paralegal

Phone number

Address

City

State

ZIP code

Are you negotiating a settlement regarding the accident?

Narrative

A very important element of our diagnosis is your description of your pain problems: when they began, where they are located, and how they affected you. Put the account in chronological order starting with the first symptoms you experienced. Please also describe what it is like on one of your worst days.

Patient Signature

Parent/Guardian Signature