Jacobelli
Exceptional General Dental Care for the Quality Conscious

Head, Neck & Facial Pain Questionnaire

This additional questionnaire was designed to draw out and document 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.

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Today's Date:

Patient Full Name:

Please **number** your complaints with #1 being the most severe symptom, #2 the next, etc. Then rate your complaints for frequency and intensity:

Frequency
1-SELDOM
2-OCCASIONAL
3-FREQUENT
4-EVERY DAY

Intensity
0 is NO PAIN
10 is MOST SEVERE PAIN

	Number #1 = the most severe symptom	**Frequency** 1-4	**Intensity** 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:		

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.			

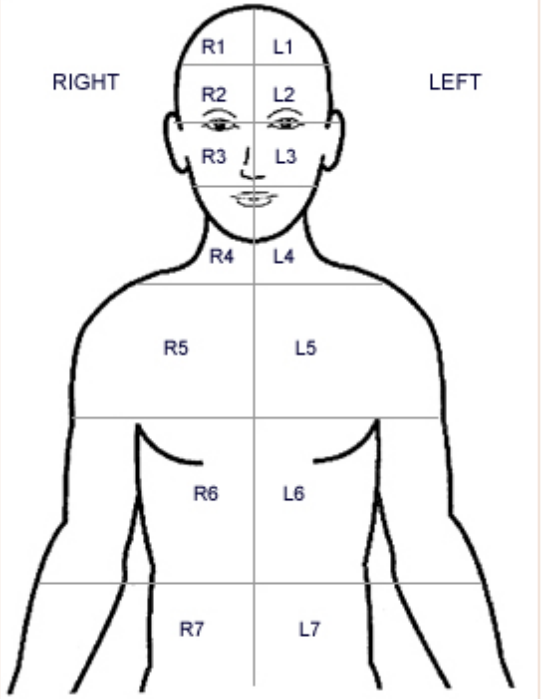
SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

Head Pain	Location	Severity	Frequency	Duration
	Front of your head (Frontal)			
	Entire head (Generalized)			
	Top of your head (Parietal)			
	Back of your head (Occipital)			
	In your temples (Temporal)			
		Mi - Mild *Mo - Moderate* *Se - Severe*	*O - Occasional* *F - Frequent* *C - Constant*	*SS- Seconds, MM - Minutes* *HH - Hours, DD - Days, WW - Weeks*

Jaw Pain		**Ear Related Conditions**	
	Jaw pain – on opening		Buzzing in the ears
	Jaw pain – while chewing		Ear congestion
	Jaw pain – at rest		Ear pain
			Hearing loss
Jaw Symptoms			Pain behind the ear
	Jaw clicks		Pain in front of the ear
	Jaw locks closed		Recurrent ear infections
	Jaw locks open		Tinnitus (ringing in the ear)
	Jaw popping		
	Teeth clenching		
	Teeth grinding	**Throat Neck & Back Related Conditions**	
			Back pain - lower
			Back pain - middle
Eye Related Conditions			Back pain - upper
	Blurred vision		Chronic sore throat
	Double vision		Constant feeling of foreugn object in throat
	Eye pain		Difficulty in swalowing
	Pain or pressure behind the eyes		Limited movement of neck
	Photophobia (extreme sensitivity to light)		Neck pain
			Numbness in the hands or fingers
Mouth & Nose Related Conditions			Sciatica
	Broken teeth		Scoliosis
	Burning tongue		Shoulder pain
	Chronic sinusitis		Shoulder stiffness
	Dry mouth		Swelling in the neck
	Frequent biting of cheek		Swollen glands
	Frequent snoring		Thyroid enlargement
	Other:		Tightness in throat
			Tingling in the hands or fingers

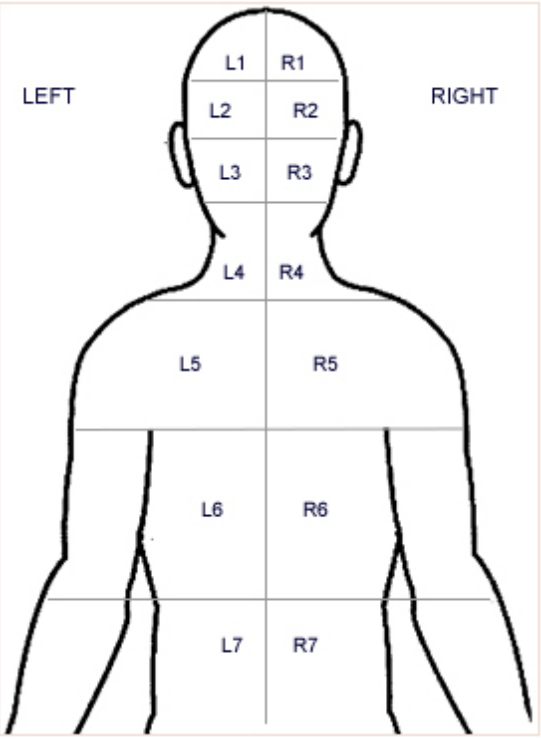
History Of Symptoms			
When did your condition first occur?			
What do you believe is the cause of your pain or condition?			
If accident, date:			
Is there anything that makes your pain or discomfort worse?			
Is there anything that makes your pain or discomfort better?			
What other information can you share that is important to your pain or condition?			
Family History			
Have any members of your family (blood kin) had:			
Headaches		High blood pressure	
Heart Disease		Diabetes	
Social History			
Occupation:			
Do you have children?	If yes, how many children?		What are their ages?
Are you currently under unusual stress?			
Recent changes in lifestyle?			
Do you exercise regularly?			
Do you chew tobacco?			
Number of caffeine drinks per day			
Do you smoke?			
Number	of per		
Alcohol consumption			

USING THE IMAGE MAP, INDICATE YOUR PAIN PATTERNS IN THE TABLE LISTED NEXT TO EACH MAGE



Indicate your pain patterns in the sectional areas using the drop down boxes given below. Use the diagram on the left to refer to the sectional area.

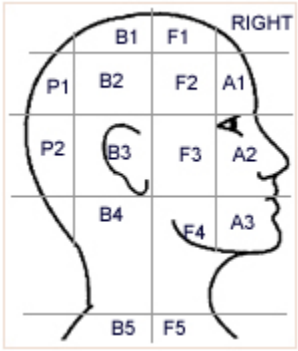
RIGHT		LEFT	
Area	**Type of Pain**	**Area**	**Type of Pain**
R1		L1	
R2		L2	
R3		L3	
R4		L4	
R5		L5	
R6		L6	
R7		L7	



Indicate your pain patterns in the sectional areas using the drop down boxes given below. Use the diagram on the left to refer to the sectional area.

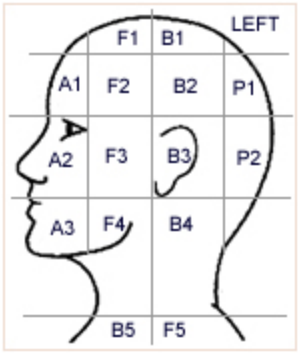
RIGHT		LEFT	
Area	**Type of Pain**	**Area**	**Type of Pain**
R1		L1	
R2		L2	
R3		L3	
R4		L4	
R5		L5	
R6		L6	
R7		L7	

Indicate your pain patterns in the sectional areas using the drop down boxes given below. Use the diagram to refer to the sectional area.



Area	Type of Pain	Area	Type of Pain	Area	Type of Pain	Area	Type of Pain
P1		B1		F1		A1	
P2		B2		F2		A2	
		B3		F3		A3	
		B4		F4			
		B5		F5			

Indicate your pain patterns in the sectional areas using the drop down boxes given below. Use the diagram to refer to the sectional area.



Area	Type of Pain	Area	Type of Pain	Area	Type of Pain	Area	Type of Pain
A1		F1		B1		P1	
A2		F2		B2		P2	
A3		F3		B3			
		F4		B4			
		F5		B5			

HISTORY OF ACCIDENT

Date of Accident or Incident	
Were you?	**And...**
If in a vehicle where was the vehicle hit?	
Indicate if there was any direct trauma	
Did your	**Forcibly strike**
Were any areas of your body painful shortly after the accident/ incident?	
Briefly describe the history of symptoms, accident or incident	
Did you go to the hospital?	|
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 this incident?	
If Yes, please explain:	
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 your insurance category

Insured	Insured's Soc. Sec. No.	
Relationship	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?

OTHER TYPES OF INSURANCE

HEALTH INSURANCE (Complete even if you are covered by auto insurance)

Insured	Insured's Soc. Sec. No.	
Relationship	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?		If yes, was treatment authorized?
Insurance Co.	Insurance Billing Address	City, State, Zip
Policy No.	Group No.	I.D. No.

Additonal Information

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?

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 Initials: Date:

Submit