TMJ

Head, Neck and Facial Pain Questionnaire

Please fill out form completely. Thank You

Please fill out this form in Adobe Acrobat Reader

Date

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PATIENT INFORMATION

Patient's Name		Phone Number Home Work Cell		
Street Address		City	State	Zip
Age	Date of Birth	Gender Male ☐ Female ☐ Other ☐	Who may we thank for referring you?	
Family Physician		Family Dentist		
In Case of Emergency, Who Should be Notified?		Relationship/Phone		

PERSON RESPONSIBLE FOR ACCOUNT INFORMATION:

Name _____

Address _____

City _____ State Zip

Home Phone _____ SS# _____

Employer Name _____

Employer Address _____

City _____ State Zip

Work Phone _____

PRIMARY MEDICAL INSURANCE INFORMATION:*

Name of Insurance _____

Address _____

City _____ State Zip

Name of Insured _____

Insured's Date of Birth _____

Insured's Employer _____

Policy/ID# _____ Effective Date

SECONDARY MEDICAL INSURANCE INFORMATION:*

Name of Insurance _____

Address _____

City _____ State Zip

Name of Insured _____

Insured's Date of Birth _____

Insured's Employer _____

Policy/ID# _____

We do not participate with any medical insurance programs. Insurance information is for patient reimbursement purposes only.

Signature of Patient, Parent, or Guardian _____ Date _____

Signature of Insured _____ Date _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?
(Please order ***YOUR*** chief complaints by number, with "1" being most important)

_____ Back Pain	_____ Jaw Clicking	_____ Pain Behind Eyes
_____ Dizziness	_____ Jaw Joint Noises	_____ Pain When Chewing
_____ Ear Pain	_____ Jaw Locking	_____ Ringing in the Ears
_____ Ear/Sinus Congestion	_____ Jaw Pain	_____ Shoulder Pain
_____ Facial Pain	_____ Limited Mouth Opening	_____ Throat Pain
_____ Fatigue	_____ Muscle Twitching	_____ Tinnitis
_____ Headaches	_____ Neck Pain	_____ Visual Disturbances
_____ Inability To Open Mouth	Other _____	

LIST TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING

	Practitioner	Specialty	Treatment & Approx. Date
1.			
2.			
3.			
4.			

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

☐ Antibiotics	☐ Latex	☐ Plastic
☐ Aspirin	☐ Local Anesthetics	☐ Sedatives
☐ Barbiturates	☐ Metals	☐ Sleeping Pills
☐ Codeine	☐ Penicillian	☐ Sulfa Drugs
☐ Iodine	Other Allergans _____	

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

☐ Antibiotics	☐ Cortisone	☐ Nerve Pills
☐ Anticoagulants	☐ Diet Pills	☐ Pain Medication
☐ Barbiturates	☐ Heart Medication	☐ Sleeping Pills
☐ Blood Thinners	☐ Insulin	☐ Sulfa Drugs
☐ Codeine	☐ Muscle Relaxants	☐ Tranquilizers
Other _____		

ARE YOU PREGNANT? Yes ☐ No ☐	IF YES, HOW FAR ALONG?

THIS SPACE FOR OFFICE USE:

MEDICAL HISTORY

- ☐ Adenoids
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune Disorders
- ☐ Bleeding Easily
- ☐ Blood Pressure- High
- ☐ Blood Presure- Low
- ☐ Bruising Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chronic Fatigue
- ☐ Cold Hands/Feet
- ☐ Current Pregnancy
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Concentrating
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Thirst
- ☐ Fluid Retention
- ☐ Frequent Cough
- ☐ Frequent Illnesses
- ☐ Frequent Stressful Situations
- ☐ General Anesthesia
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay Fever
- ☐ Hearing Impairment

Other Medical/Dental History

- ☐ Heart Murmur
- ☐ Heart Disorder
- ☐ Heart Pacemaker
- ☐ Heart Palpitations
- ☐ Heart Valve Replacement
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hypoglycemia
- ☐ Immune System Disorder
- ☐ Injury to Face
- ☐ Injury to Mouth
- ☐ Injury to Neck
- ☐ Injury to Teeth
- ☐ Insomnia
- ☐ Intestinal Disorders
- ☐ Jaw Joint Surgery
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Meniere's Disease
- ☐ Menstrual Cramps
- ☐ Multiple Sclerosis
- ☐ Muscle Aches
- ☐ Muscle Shaking (Tremors)
- ☐ Muscle Spasms or Cramps
- ☐ Muscular Dystrophy
- ☐ Needing Extra Pillows to Help Breathing at Night
- ☐ Nervous System Irritability
- ☐ Nervousness
- ☐ Neuralgia

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Ovarian Cysts
- ☐ Parkinson's Disease
- ☐ Poor Circulation
- ☐ Prior Orthodontic Treatment
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Disorder
- ☐ Slow-Healing Sores
- ☐ Snoring
- ☐ Speech Difficulties
- ☐ Stroke
- ☐ Swollen, Stiff or Painful Joints

Tendency For:

- ☐ Ear Infections
- ☐ Frequent Colds
- ☐ Sore Throats
- ☐ Tired Muscles
- ☐ Tonsils Removed
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Urinary Disorders
- ☐ Wisdom Teeth (3rd Molar) Extraction
- ☐ Yeast Infections

SYMPTOMS

L=Left R= Right B= Both Sides

Head Pain

	Location	Severity			Frequency			Duration				
		MILD	MODERATE	SEVERE	OCCASIONAL	FREQUENT	CONSTANT	SECONDS	MINUTES	HOURS	DAYS	WEEKS
N/A	Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
N/A	Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
N/A	Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
N/A	Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
N/A	In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Jaw Pain

N/A Jaw pain- upon opening _____

N/A Jaw pain- while chewing _____

N/A Jaw pain- at rest _____

Jaw Symptoms

- ☐ Jaw clicks _____
- ☐ Jaw locks closed _____
- ☐ Jaw locks open _____
- ☐ Jaw popping _____
- ☐ Teeth clenching _____
- ☐ Teeth grinding _____

MEDICAL HISTORY (continued)

Eye-Related Conditions

N/A Blurred vision
N/A Double vision
N/A Eye pain
N/A Pain/Pressure behind eyes
N/A Photophobia (light sensitivity)

Ear Related Conditions

☐ Buzzing in the ears
☐ Ear congestion
☐ Ear pain
☐ Hearing loss
☐ Pain behind ear
☐ Pain in front of ear
☐ Recurent ear infections
☐ Tinnitus (ringing in the ear)

Throat, Neck & Back Related Conditions

☐ Back pain- upper
☐ Back pain- middle
☐ Back pain- lower
☐ Chronic sore throat
☐ Constant feeling of a foreign object in throat
☐ Difficulty swallowing
☐ Limited neck movement
☐ Neck pain
☐ Hand/finger numbness
☐ Other _____

☐ Sciatica
☐ Scoliosis
☐ Shoulder pain
☐ Shoulder stiffness
☐ Swelling in the neck
☐ Swollen glands
☐ Thyroid enlargement
☐ Tightness in throat
☐ Tingling hands/fingers
☐ Wryneck

Mouth & Nose Related Conditions

☐ Broken teeth
☐ Burning tongue
☐ Chronic sinusitis
☐ Dry mouth
☐ Frequent biting of cheek
☐ Frequent snoring

Lifestyle Related Conditions

☐ Currently under unusual stress
☐ Recent change in lifestyle
☐ Recent change in work pattern

Do you drink 2 or more alcoholic beverages per day? Yes ☐ No ☐	Substance Dependency? Yes ☐ No ☐ _____
Do you drink 4 or more cups of coffee per day? Yes ☐ No ☐	Do you smoke tobacco? Yes ☐ No ☐ _____
Does any family member have the same or similar problem? Yes ☐ No ☐	

If yes, please explain _____

What makes your discomfort/pain worse? _____

HISTORY OF SYMPTOMS

When did your condition first occur? _____

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

☐ Athletic endeavor ☐ Fight ☐ Fall ☐ Accident ☐ Heredity ☐ Illness ☐ Injury
☐ Unknown ☐ If accident, date _____
☐ Other _____

What other information is important to your pain or condition?

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