

# 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
#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:**

- |   |              |   |                   |   |                |
|---|--------------|---|-------------------|---|----------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Antibiotics  | <input type="checkbox"/> Y <input type="checkbox"/> N | Latex             | <input type="checkbox"/> Y <input type="checkbox"/> N | Sedatives      |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Aspirin      | <input type="checkbox"/> Y <input type="checkbox"/> N | Local anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N | Sleeping pills |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Barbiturates | <input type="checkbox"/> Y <input type="checkbox"/> N | Metals            | <input type="checkbox"/> Y <input type="checkbox"/> N | Sulfa drugs    |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Codeine      | <input type="checkbox"/> Y <input type="checkbox"/> N | Penicillin        | <input type="checkbox"/> Y <input type="checkbox"/> N | Other _____    |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Iodine       | <input type="checkbox"/> Y <input type="checkbox"/> N | Plastic           |   | _____          |

**LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:**

- |   |                |   |                  |   |                 |
|---|----------------|---|------------------|---|-----------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Antibiotics    | <input type="checkbox"/> Y <input type="checkbox"/> N | Cortisone        | <input type="checkbox"/> Y <input type="checkbox"/> N | Nerve pills     |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Anticoagulants | <input type="checkbox"/> Y <input type="checkbox"/> N | Diet pills       | <input type="checkbox"/> Y <input type="checkbox"/> N | Pain medication |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Barbiturates   | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart medication | <input type="checkbox"/> Y <input type="checkbox"/> N | Sleeping pills  |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Blood thinners | <input type="checkbox"/> Y <input type="checkbox"/> N | Insulin          | <input type="checkbox"/> Y <input type="checkbox"/> N | Sulfa drugs     |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Codeine        | <input type="checkbox"/> Y <input type="checkbox"/> N | Muscle relaxants | <input type="checkbox"/> Y <input type="checkbox"/> 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)**

- |   |   |   |                               |   |                         |
|---|---|---|-------------------------------|---|-------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Adenoids Removed  | <input type="checkbox"/> Y <input type="checkbox"/> N | Current pregnancy             | <input type="checkbox"/> Y <input type="checkbox"/> N | General anesthesia      |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Tonsils Removed   | <input type="checkbox"/> Y <input type="checkbox"/> N | Depression                    | <input type="checkbox"/> Y <input type="checkbox"/> N | Glaucoma                |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Anemia  | <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes                      | <input type="checkbox"/> Y <input type="checkbox"/> N | Gout                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Arteriosclerosis  | <input type="checkbox"/> Y <input type="checkbox"/> N | Difficulty concentrating      | <input type="checkbox"/> Y <input type="checkbox"/> N | Hay fever               |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma  | <input type="checkbox"/> Y <input type="checkbox"/> N | Dizziness                     | <input type="checkbox"/> Y <input type="checkbox"/> N | Hearing impairment      |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Autoimmune disorders  | <input type="checkbox"/> Y <input type="checkbox"/> N | Emphysema                     | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart murmur            |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Bleeding easily   | <input type="checkbox"/> Y <input type="checkbox"/> N | Epilepsy                      | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart disorder          |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Blood pressure <input type="checkbox"/> High <input type="checkbox"/> Low | <input type="checkbox"/> Y <input type="checkbox"/> N | Excessive thirst              | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart pacemaker         |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Bruising easily   | <input type="checkbox"/> Y <input type="checkbox"/> N | Fibromyalgia                  | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart palpitations      |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Cancer  | <input type="checkbox"/> Y <input type="checkbox"/> N | Fluid retention               | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart valve replacement |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Chemotherapy  | <input type="checkbox"/> Y <input type="checkbox"/> N | Frequent cough                | <input type="checkbox"/> Y <input type="checkbox"/> N | Hemophilia              |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Chronic fatigue   | <input type="checkbox"/> Y <input type="checkbox"/> N | Frequent illnesses            | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis               |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Cold hands & feet   | <input type="checkbox"/> Y <input type="checkbox"/> N | Frequent stressful situations | <input type="checkbox"/> Y <input type="checkbox"/> N | Hypoglycemia            |

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY CONTINUED**

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

**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		OCCASIONAL (MONTHLY OR LESS)	FREQUENT (WEEKLY)	CONSTANT (EVERY DAY)	SECONDS	MINUTES	HOURS	DAYS	WEEKS
				SEVERE								
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"/>
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"/>
L R B	Top of your head (Parietal)	<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"/>
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"/>

**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:*

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

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  Recent change in lifestyle?
- Y  N  Do you exercise regularly?

Y  N  Do you chew tobacco?  
 Number of caffeine drinks per day \_\_\_\_\_




Y <input type="checkbox"/> N <input type="checkbox"/> Do you smoke?
_____ Number of <input type="checkbox"/> Packs <input type="checkbox"/> Cigarettes per <input type="checkbox"/> Day <input type="checkbox"/> Week

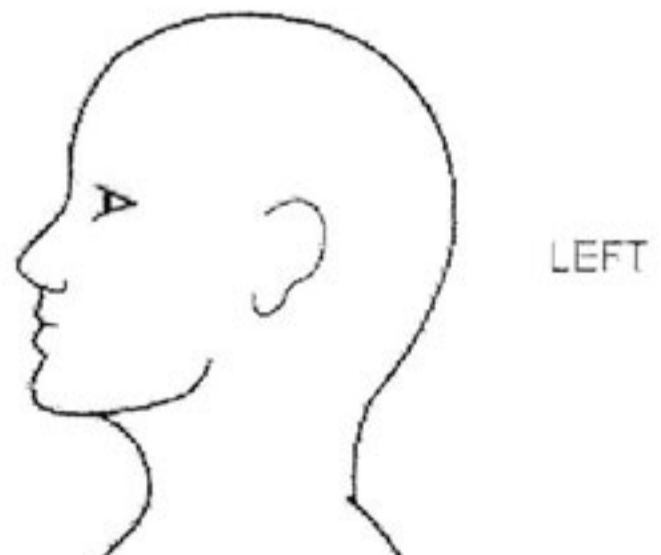
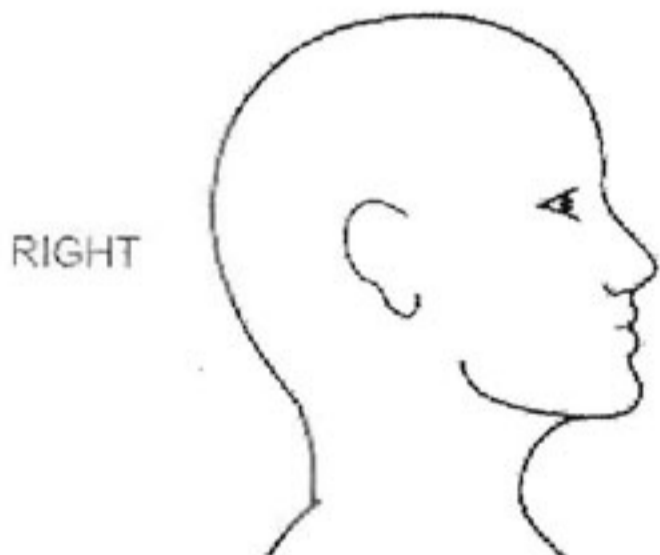
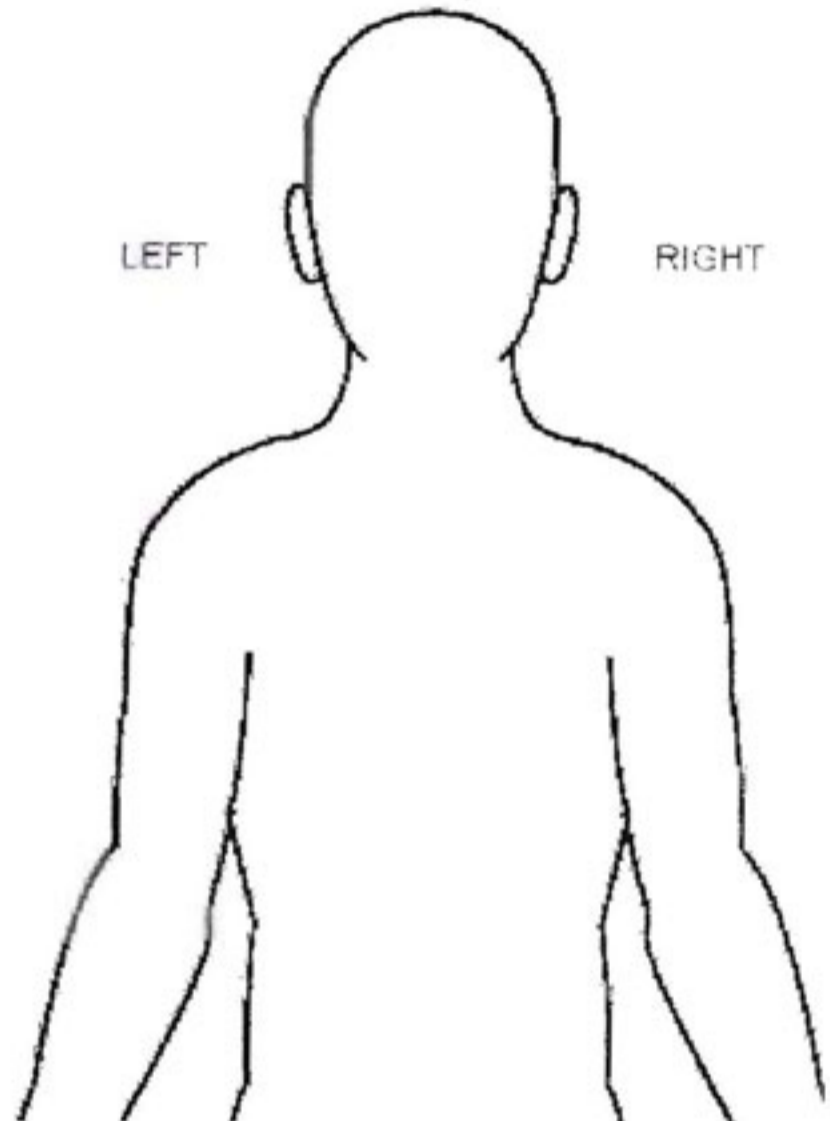
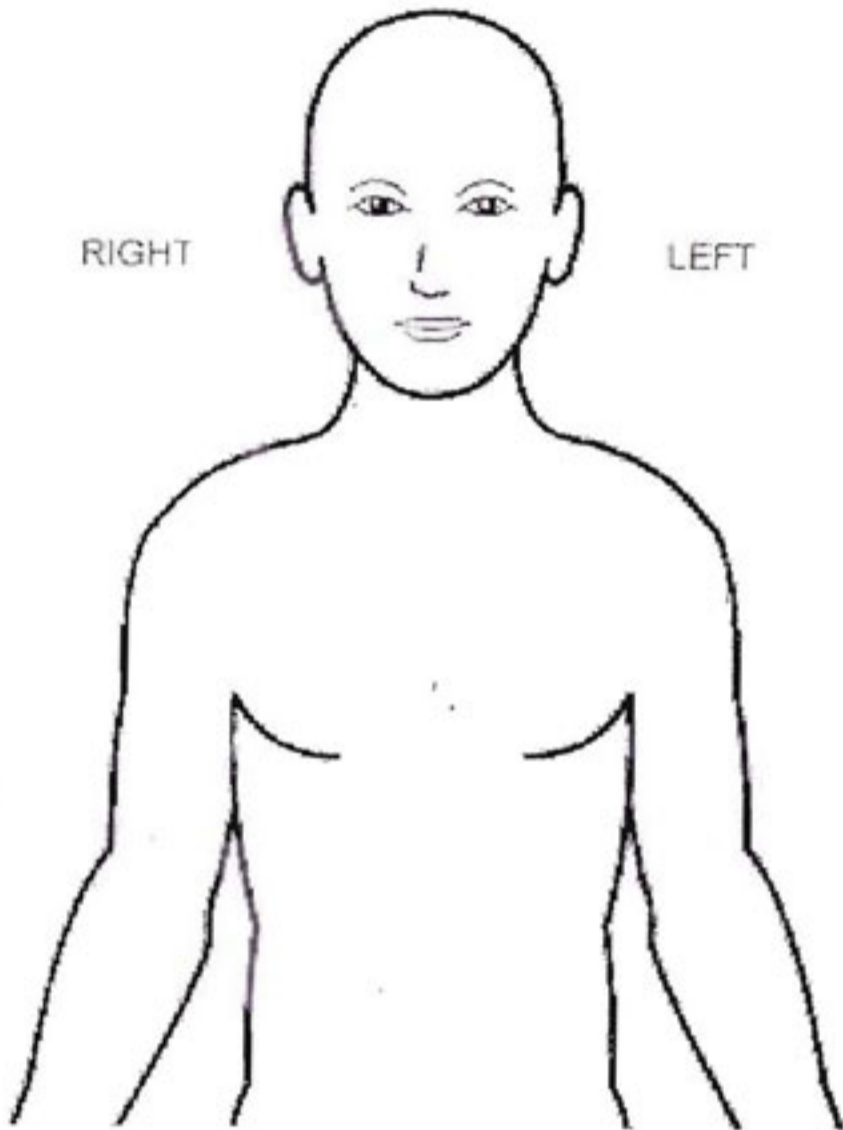
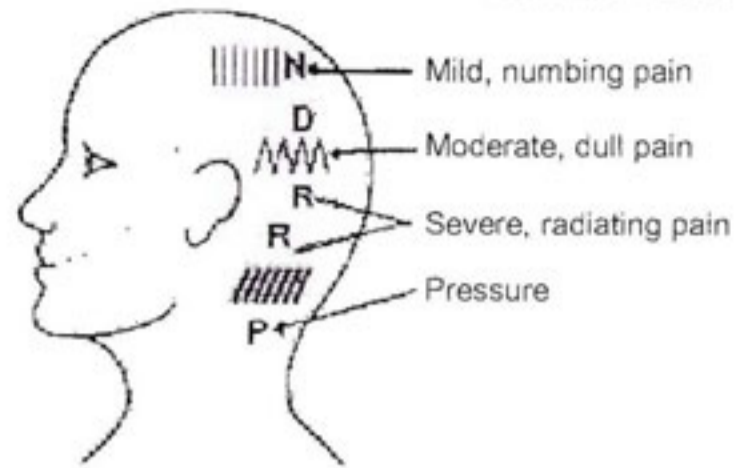
<i>Alcohol consumption</i>	
<input type="checkbox"/> None	<input type="checkbox"/> Social Drinker
<input type="checkbox"/> Occasional	<input type="checkbox"/> Daily

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:**

**EXAMPLE**

- |               |   |             |
|---------------|---|-------------|
| MILD PAIN     |  | B Burning   |
|               |   | D Dull      |
| MODERATE PAIN |  | N Numbing   |
|               |   | P Pressure  |
| SEVERE PAIN   |  | S Sharp     |
|               |   | T Tingling  |
|               |   | R Radiating |



Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

# HISTORY OF ACCIDENT

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 \_\_\_\_\_