

HEAD, NECK AND FACIAL PAIN DIAGNOSIS

Today's Date: _____

Patient Name: _____

Age: _____

Please answer the following questions, as they are very important to completing your health history.

Do you ever have any of the following symptoms? Please Print.

Please Circle

- | | | |
|------------------------------------------------------------|-----|----|
| 1. Headaches | Yes | No |
| 2. Dizziness | Yes | No |
| 3. Lightheadedness | Yes | No |
| 4. Neckaches or stiffness in the neck | Yes | No |
| 5. Pain or Stiffness in the shoulders | Yes | No |
| 6. Pain in the jaw joint | Yes | No |
| 7. Pain in front of the ears | Yes | No |
| 8. Pain in facial muscles | Yes | No |
| 9. Sore throat | Yes | No |
| 10. Are you easily fatigued or tired at the end of the day | Yes | No |
| 11. Forgetfulness or difficulty in learning new material | Yes | No |
| 12. Ringing and buzzing or other sounds in the ears | Yes | No |
| 13. Feeling of fullness in the ears or sinuses | Yes | No |
| 14. Numbness or tingling of the fingertips | Yes | No |
| 15. Backaches: ___Upper ___Mid ___Lower | Yes | No |
| 16. Clicking sounds from the jaw joint ___Right ___Left | Yes | No |
| 17. Popping sounds from the jaw joint ___Right ___Left | Yes | No |
| 18. Difficulty in opening the mouth fully | Yes | No |
| 19. Difficulty in opening and closing the mouth | Yes | No |
| 20. Pain in teeth: ___Upper ___Lower | Yes | No |
| 21. Pain in, around, or behind eyes | Yes | No |
| 22. Visual problems (eyesight getting worse) | Yes | No |
| 23. Clench teeth during the day | Yes | No |
| 24. Grind teeth at night | Yes | No |
| 25. Frequent stress encounters ___Home ___Work | Yes | No |
| 26. Received orthodontic treatment | Yes | No |
| 27. Wisdom teeth been removed. When _____ | Yes | No |

Under what circumstances did the pain begin? _____

What do you think is the cause of your pain? _____

Are you currently taking any medications for these symptoms? If yes please list _____

Please list your most severe symptoms (aches, pains, etc.), frequency, duration, severity, and when they started. Start with the most severe symptom.

Symptoms	How Often	How Long	How Severe	First Started
1. _____				
2. _____				
3. _____				
4. _____				