

Date / /

Please fill out form **completely**. Thank You

PATIENT INFORMATION

Patient's Name _____ Social Security No _____ Home Phone _____
 Street Address _____ City _____ State _____ Zip Code _____
 Date of Birth / / Gender Male Female Marital Status Single Married Widowed Divorced Separated
 In case of emergency who should be notified? _____ Relationship/Phone _____ Whom may we thank for referring you? _____

EMPLOYER'S INFORMATION

Employer's Name _____ Present Position _____ Work Phone _____
 Street Address _____ City _____ State _____ Zip Code _____

SPOUSE'S INFORMATION

Spouse's Name _____ Spouse's Social Security No _____

PATIENT'S MEDICAL HEALTH INFORMATION

Physician's Name _____ Physician's Phone _____ Physician's Street Address _____
 Date of Last Complete Physical / / List medications you are taking _____

Are you or have you been treated for:

Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Congenital Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ulcer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
TB or Lung Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma or Hay Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do You Snore?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pace Maker	Yes <input type="checkbox"/> No <input type="checkbox"/>		
HIV Positive	Yes <input type="checkbox"/> No <input type="checkbox"/>				

Do you currently take a multivitamin? Yes No

If yes, how many multivitamin pills or capsules do you take daily? a 1-3 a 4-6 a 7 or more

Other than a multivitamin, what supplements do you take? (Please check all that apply)

- Vitamin C
- Vitamin E
- Calcium
- Garlic
- CoEnzyme Q10
- B-Complex
- Beta Carotene
- Ginko Biloba
- Magnesium
- Ginseng
- L-Carnitine
- Saw Palmetto
- Chromium
- Melatonin
- Glucosamine Sulfate
- Fiber
- DHEA

Other: _____

Are you allergic to Local anesthetics? Yes No Penicillin Yes No Codeine Yes No Other Medications or drugs Yes No If Yes, which? _____

Are you subject to prolonged bleeding? Yes No Are you subject to fainting spells? Yes No Do you have excessive urination and/or thirst? Yes No

Do you have any other conditions you feel we should know? _____

WOMEN → Are you pregnant? Yes No If yes, how long? _____ Any Complications? _____

Witness _____ Patient, Parent, Guardian _____ Date _____

Please complete reverse side.

HEAD, NECK AND FACIAL PAIN QUESTIONNAIRE

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 and determining the source of your problem. 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 NAME: _____
 MRS. DR. FIRST MIDDLE INITIAL LAST
AGE: _____ DATE OF BIRTH: _____ Male Female
ADDRESS: _____
CITY/STATE/ZIP _____
HOW LONG AT CURRENT ADDRESS? _____ (IF LESS THAN 3-YEARS PLEASE GIVE PREVIOUS ADDRESS)
PREVIOUS ADDRESS _____
EMPLOYED BY _____
ADDRESS: _____
REFERRED BY: _____
INSURANCE CLAIM NUMBER: _____ SS#: _____
HOME PHONE: _____ BUSINESS PHONE: _____
RESPONSIBLE PARTY: _____
ADDRESS IF DIFFERENT FROM PATIENT: _____
FAMILY PHYSICIAN: _____
ADDRESS: _____
FAMILY DENTIST: _____
ADDRESS: _____

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

Please order **your** chief complaints by number with 1 being most important.)

- | | | |
|--|--|--|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Jaw Clicking | <input type="checkbox"/> Pain behind Eyes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw Joint Noises | <input checked="" type="radio"/> Pain when Chewing |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Jaw Locking | <input type="checkbox"/> Ringing in the Ears |
| <input type="checkbox"/> Ear/Sinus Congestion | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Facial Pain | <input checked="" type="radio"/> Limited Mouth Opening | <input type="checkbox"/> Throat Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Muscle Twitching | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Inability to open mouth | | |

Other:

Patient Signature _____ Date _____

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

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

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

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

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

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. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

MEDICAL HISTORY

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

MEDICAL HISTORY

CONTINUED

- Immune system disorder
- Injury to
 - Face Mouth
 - Neck 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
- Other **Medical/Dental** History _____

- a** Muscular dystrophy
- a** 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
- Speech difficulties
- Stroke
- Swollen, stiff or painful joints
- Tendency for Frequent Colds
- Ear Infections Sore Throats
- Tired muscles
- Tuberculosis
- Tumors
- Urinary disorders
- Wisdom teeth (Third 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	
L	R	B	Front of your head (Frontal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L	R	B	Entire head (Generalized)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L	R	B	Top of your head (Parietal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
L	R	B	Back of your head (Occipital)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

JAW PAIN

L	R	B	Description	Severity
			Jaw pain - on opening	_____
			Jaw pain - while chewing	_____
			Jaw pain - at rest	_____

JAW SYMPTOMS

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

EYE RELATED CONDITIONS

- Blurred vision _____
- Double vision _____
- Eye pain _____
- Pain or pressure behind the eyes _____
- Photophobia (extreme sensitivity to light) _____

EAR RELATED CONDITIONS

- Buzzing in the ears _____
- Ear congestion _____
- Ear pain _____
- Hearing loss _____
- Pain behind the ear _____

Patient Signature _____ Date _____

EAR RELATED CONDITIONS CONTINUED

- Pain in front of the ear _____
- Recurrent ear infections _____
- Tinnitus (ringing in the ear) _____

THROAT NECK & BACK RELATED CONDITIONS

- Back pain - lower _____
- Back pain - middle _____
- Back pain - upper _____
- Chronic sore **throat** _____
- Constant** feeling of a **foreign** object in throat _____
- Difficulty** in swallowing _____
- Limited movement of neck _____
- Neck pain _____
- Numbness in the hands or fingers _____
- Sciatica** _____
- Scoliosis** _____
- Shoulder pain _____
- Shoulder **stiffness** _____
- Other _____

THROAT NECK & BACK RELATED CONDITIONS CONTINUED

- Swelling in the neck _____
- Swollen glands _____
- Thyroid enlargement _____
- lightness in throat _____
- Tingling in the **hands** or **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?** _____

Do you drink **4** or more cups of coffee per day? Yes No **Smoke tobacco?** Yes No

Does any family **member** have the same or a 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?

- Motor vehicle accident Motorcycle accident Work related incident Playground incident
- Athletic endeavor fight Fall Accident Heredity Illness **Injury**
- Unknown **If accident**, date _____
- Other _____

What other **information** is important to your pain or condition? _____

Patient Signature _____ Date _____

FOR OFFICE USE

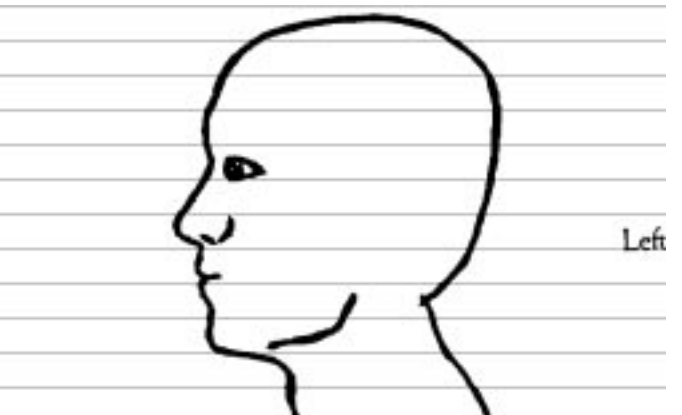
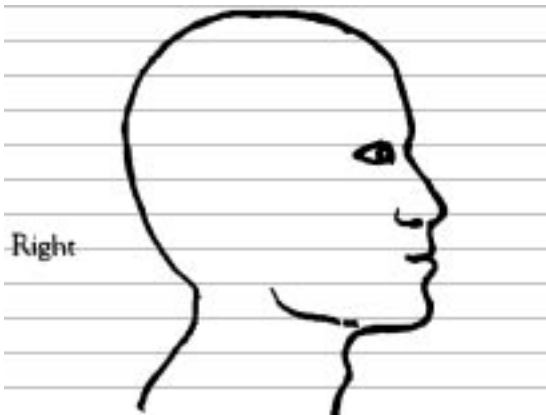
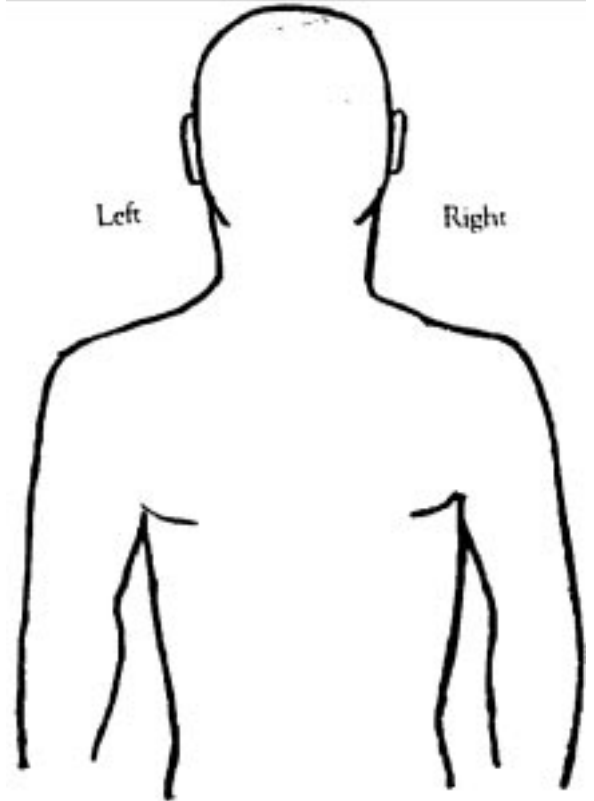
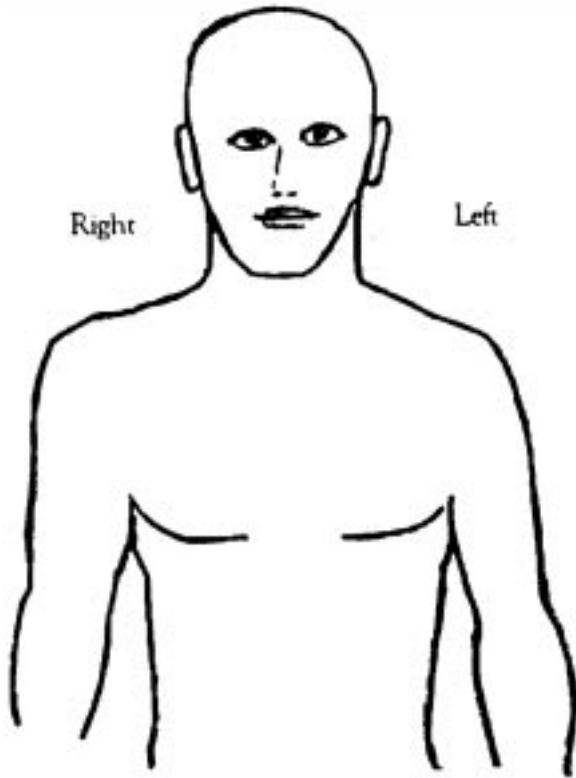
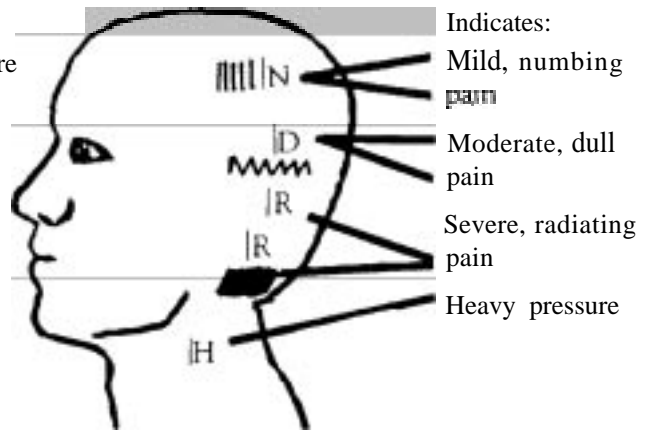
- Extent of medical history obtained on _____ consisted of:
- Chief complaint(s) Extended history of present illness
 - Review of systems related to problem Review of all **additional** body systems
 - Complete past history Complete **family** history Complete **social** history

DRAW YOUR PAIN PATTERNS
FOLLOWING THIS KEY:

- |||| MILD PAIN
- ~~~~ MODERATE PAIN
- _____ SEVERE PAIN

- B Burning
- D Dull
- H Heavy Pressure
- N Numbing
- S Sharp
- T Tingling
- R Radiating

EXAMPLE:



Patient Signature _____

Date _____