

# Raleigh Facial Pain Center

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## NEW PATIENT INFORMATION

PLEASE PRINT LEGIBLY

|  |                                 |                                  |                                  |                                    |                                   |                                  |                                 |
|--|---------------------------------|----------------------------------|----------------------------------|------------------------------------|-----------------------------------|----------------------------------|---------------------------------|
| Patient Full Name:                     |                                 |                                  |                                  |                                    |                                   | <input type="checkbox"/> Male    | <input type="checkbox"/> Female |
| Nickname/Preferred Name:               |                                 |                                  | Date of Birth:                   |                                    |                                   | Age:                             |                                 |
| Social Security Number:                |                                 |                                  | Drivers License Number/State:    |                                    |                                   |                                  |                                 |
| Marital Status:                        | <input type="checkbox"/> Single | <input type="checkbox"/> Engaged | <input type="checkbox"/> Married | <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |                                 |
| Home Address:                          |                                 |                                  | City/State:                      |                                    |                                   | ZIP Code:                        |                                 |
| Home Phone:<br>( )                     | Work Phone:<br>( )              | Cell Phone:<br>( )               |                                  | Email:                             |                                   |                                  |                                 |
| Employer:                              |                                 | Job Title:                       |                                  |                                    | Work Hours:                       |                                  |                                 |
| Work Address:                          |                                 | City/State:                      |                                  |                                    | ZIP Code:                         |                                  |                                 |
| Spouse Name:                           |                                 | Work Phone:<br>( )               |                                  | Cell Phone:<br>( )                 |                                   |                                  |                                 |
| Employer:                              |                                 | Job Title:                       |                                  |                                    | Work Hours:                       |                                  |                                 |
| Work Address:                          |                                 | City/State:                      |                                  |                                    | ZIP Code:                         |                                  |                                 |
| Children's Names and Ages:             |                                 |                                  |                                  |                                    |                                   |                                  |                                 |
| Additional Contact ( <b>Required</b> ) |                                 | Relationship                     | Home Phone:<br>( )               | Cell Phone:<br>( )                 | Work Phone:<br>( )                |                                  |                                 |

## HEALTHCARE PROVIDERS INFORMATION

|   |  |           |  |  |  |               |  |
|---|--|-----------|--|--|--|---------------|--|
| Who may we thank for referring you?           |  |           |  |  |  |               |  |
| Primary Care Physician:                       |  |           |  | Send reports to this provider?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | Phone:<br>( ) |  |
| Office Address:                               |  |           |  |  |  |               |  |
| Date of Last Appointment:                     |  | Findings: |  |  |  |               |  |
| Primary Dental Care Provider:                 |  |           |  |  |  | Phone:<br>( ) |  |
| Office Address:                               |  |           |  |  |  |               |  |
| Date of Last Appointment:                     |  | Findings: |  |  |  |               |  |
| Other Care Providers (Name, Specialty, Phone) |  |           |  |  |  |               |  |

### MEDICAL INSURANCE INFORMATION

|  |             |                      |  |
|--|-------------|----------------------|--|
| Insurance Company:   |             | Phone: (     )       |  |
| Mailing Address:   | City/State: | ZIP Code:            |  |
| Member/Subscriber Number:  |             | Group/Policy Number: |  |
| Type of Plan: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Open Access <input type="checkbox"/> Self-Funded <input type="checkbox"/> Supplemental <input type="checkbox"/> Other<br>(please specify) |             |                      |  |
| Gatekeeper, if applicable:   |             | Phone: (     )       |  |
| Policy Holder's / Subscriber's Name:   |             | Relationship:        |  |
| Social Security Number:  |             | Date of Birth:       |  |
| Address, if not same as patient:   |             |                      |  |

### PATIENT CONSENT

I hereby authorize Raleigh Facial Pain Center to release medical information to my insurance company, referring doctor, physician, lawyer, and any healthcare provider used in the management of my care. I authorize release of information to Raleigh Facial Pain Center from other healthcare providers involved in my medical care.

I understand that it is my responsibility as a patient to keep my medical information up-to-date and to advise Raleigh Facial Pain Center of any changes in my health, medications, or other healthcare issues. I agree to abide by all state and federal guidelines if I receive medications or obtain a certificate of disability. I understand that it is my responsibility to obtain insurance pre-authorization if it is necessary. I understand that neither Medicare nor Medicaid will reimburse for services provided by Raleigh Facial Pain Center and I waive my right to seek reimbursement under either or both Medicare and Medicaid programs.

|                             |                              |              |
|-----------------------------|------------------------------|--------------|
| <b>Patient's signature:</b> | <b>Printed Patient Name:</b> | <b>Date:</b> |
|-----------------------------|------------------------------|--------------|

I have reviewed a copy of the Notice of Privacy Practices for Raleigh Facial Pain Center. I give permission for the Staff of Raleigh Facial Pain Center to contact me in the following methods and to leave voice messages as noted:

|             |                              |                             |                                  |          |
|-------------|------------------------------|-----------------------------|----------------------------------|----------|
| Home Phone: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Message | Number:  |
| Cell Phone: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Message | Number:  |
| Work Phone: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Message | Number:  |
| Fax:        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                                  | Number:  |
| Email:      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                                  | Address: |

Specify Any Other:

I further give permission for the staff of Raleigh Facial Pain Center to speak with the following family or personal support people regarding my healthcare:

|       |               |
|-------|---------------|
| Name: | Relationship: |
| Name: | Relationship: |
| Name: | Relationship: |

|                             |                              |              |
|-----------------------------|------------------------------|--------------|
| <b>Patient's signature:</b> | <b>Printed Patient Name:</b> | <b>Date:</b> |
|-----------------------------|------------------------------|--------------|

### Office Use Only

An attempt was made for written acknowledgement of our Notice of Privacy Practices but could not be obtained because:

|  |   |  |                                 |
|--|---|--|---------------------------------|
| <input type="checkbox"/> Patient refused to sign | <input type="checkbox"/> Communication barriers prevented obtaining acknowledgement | <input type="checkbox"/> An emergency situation prohibited obtaining acknowledgement | <input type="checkbox"/> Other: |
|--|---|--|---------------------------------|

**PRIMARY CONDITION DETAILS**

Complete a copy of this page for each location of pain, dysfunction, or concern.  
Describe **ONE and ONLY ONE** body part per page.

Define location (Write **ONE and ONLY ONE** word) \_\_\_\_\_ EXAMPLES: "jaw", "ear", "joint", "mouth", "tooth"

Problem Occurs: (check **ONE**)     Left side only     Right side only     Both sides     Switches sides

First Noticed: (Date) \_\_\_\_\_ Describe original onset: \_\_\_\_\_

Trauma: (list years occurred) \_\_\_\_\_ Auto accidents: \_\_\_\_\_ Falls: \_\_\_\_\_ Blows to head: \_\_\_\_\_

**Print from website and complete additional forms (motor vehicle accident and/or trauma) to provide details.**

Pain Levels: Average (check **ONLY one**)     None     Mild     Moderate     Severe

Worst pain: (circle **ONE** number)    no pain    0    1    2    3    4    5    6    7    8    9    10    most pain ever

Least pain: (circle **ONE** number)    no pain    0    1    2    3    4    5    6    7    8    9    10    most pain ever  
Circle 0 if not constant pain

Average pain: (circle **ONE** number)    no pain    0    1    2    3    4    5    6    7    8    9    10    most pain ever

Type of pain: (check all that apply)     Dull     Sharp     Deep     Superficial     Burning     Aching  
 Shooting     Tingling     Throbbing     Crawling     Other: \_\_\_\_\_

Since it started, it is:     Same     Better     Worse    If worse, increased:     Frequency     Severity     Duration

**Definitions:**    **Episodic pain:** some periods are pain-free    **Constant pain:** continuous with flares of increased pain

If episodic, onset is:     Gradual     Abrupt    If constant, flares occur:     Gradually     Abruptly

Frequency of episodes or flares: (number) \_\_\_\_\_ Times per: (check only one)     Day     Week     Month

Duration of episodes or flares: (number for **only one**) \_\_\_\_\_ Seconds    Minutes    Hours

Worst time of day: (check **one**)     Awakening     Morning     Afternoon     Evening     Night     Sleeping

Worse as the day progresses?     Yes     No    Better as the day progresses?     Yes     No

Worse on workdays?     Yes     No    Affected by weather?     Yes     No

Does condition interrupt sleep?     Yes     No    Family members with same concern?     Yes     No

What increases the problem? (check **all that apply**)     Chewing     Yawning     Talking     Biting  
 Physical activity     Clenching     Touching face     Opening wide     Certain foods     Weather     Stress  
 Emotional upset     Cold liquids     Head movement     Menstruation     Other: \_\_\_\_\_

What decreases the problem? (check **all that apply**)     Relaxation     Sleep     Exercise     Soft diet  
 Massage     Heat     Cold     Other: \_\_\_\_\_

Medications that help: (names, dosage) \_\_\_\_\_

Medications and Therapies that DID NOT help: (names, dosage) \_\_\_\_\_

Healthcare Providers who have treated: (name, specialty, treatment provided) \_\_\_\_\_

What lifestyle changes have you made due to pain/dysfunction? \_\_\_\_\_

What else do you notice when the condition occurs? Describe any additional concern that occurs with or because of primary condition. **If it is a separate pain or concern, complete an additional form. If you are not sure, report separately.**

\_\_\_\_\_

## NECK PAIN DETAILS

Provide requested information if you have or ever had neck pain or if you have ever sought treatment for neck pain – no matter how minor or how far in the past.

**I have never had any neck pain or trauma of any type. \_\_\_\_\_ (initial if this is true for you)**

Problem Occurs: (check **ONE**)     Left side only     Right side only     Both sides     Switches sides

First Noticed: (Date) \_\_\_\_\_ Describe original onset: \_\_\_\_\_

Trauma: (list years occurred) \_\_\_\_\_ Auto accidents: \_\_\_\_\_ Falls: \_\_\_\_\_ Blows to head: \_\_\_\_\_

**Print from website and complete additional forms (motor vehicle accident and/or trauma) to provide details.**

Pain Levels: Average (check **ONLY one**)     None     Mild     Moderate     Severe

Worst pain: (circle **ONE** number)    no pain    0    1    2    3    4    5    6    7    8    9    10    most pain ever

Least pain: (circle **ONE** number)    no pain    0    1    2    3    4    5    6    7    8    9    10    most pain ever  
Circle 0 if not constant pain

Average pain: (circle **ONE** number)    no pain    0    1    2    3    4    5    6    7    8    9    10    most pain ever

Type of pain: (check all that apply)     Dull     Sharp     Deep     Superficial     Burning     Aching  
 Shooting     Tingling     Throbbing     Crawling     Other: \_\_\_\_\_

Since it started, it is:     Same     Better     Worse    If worse, increased:     Frequency     Severity     Duration

**Definitions:**    **Episodic pain:** *some periods are pain-free*    **Constant pain:** *continuous with flares of increased pain*

If episodic, onset is:     Gradual     Abrupt    If constant, flares occur:     Gradually     Abruptly

Frequency of episodes or flares: (number) \_\_\_\_\_ Times per: (check only one)     Day     Week     Month

Duration of episodes or flares: (number for **only one**) \_\_\_\_\_ Seconds    Minutes    Hours

Worst time of day: (check **one**)     Awakening     Morning     Afternoon     Evening     Night     Sleeping

Worse as the day progresses?     Yes     No    Better as the day progresses?     Yes     No

Worse on workdays?     Yes     No    Affected by weather?     Yes     No

Does condition interrupt sleep?     Yes     No    Family members with same concern?     Yes     No

What increases the problem? (check **all that apply**)     Chewing     Yawning     Talking     Biting  
 Physical activity     Clenching     Touching face     Opening wide     Certain foods     Weather     Stress  
 Emotional upset     Cold liquids     Head movement     Menstruation     Other: \_\_\_\_\_

What decreases the problem? (check **all that apply**)     Relaxation     Sleep     Exercise     Soft diet  
 Massage     Heat     Cold     Other: \_\_\_\_\_

Medications that help: (names, dosage) \_\_\_\_\_

Medications and Therapies that DID NOT help: (names, dosage) \_\_\_\_\_

Healthcare Providers who have treated: (name, specialty, treatment provided) \_\_\_\_\_

What lifestyle changes have you made due to pain/dysfunction? \_\_\_\_\_

What else do you notice when the condition occurs? Describe any additional concern that occurs with or because of primary condition. **If it is a separate pain or concern, complete an additional form. If you are not sure, report separately.**



## HEADACHE HISTORY

**Report all headaches, no matter how minor or infrequent. Separate migraines from other headaches.  
Describe **ONE and ONLY ONE** headache type and/or location per page.**

Do you ever have headaches?  No  Yes Frequency: (number) \_\_\_per day \_\_\_per week \_\_\_per month

Location (**ONE and ONLY ONE**)  Side of head  Back of head  Behind eyes  Whole head

When did you start having headaches? Date: \_\_\_\_\_ Age: \_\_\_\_\_

Do you have any warning before headaches start?  No  Yes Describe: \_\_\_\_\_

Is headache associated with another event, condition or circumstance?  No  Yes

Explain: \_\_\_\_\_

Duration of headache: (enter a number) \_\_\_\_\_ seconds \_\_\_\_\_ minutes \_\_\_\_\_ hours \_\_\_\_\_ days

Worst pain: (circle **ONE** number) no pain 0 1 2 3 4 5 6 7 8 9 10 most pain ever

Least pain: (circle **ONE** number) no pain 0 1 2 3 4 5 6 7 8 9 10 most pain ever  
Circle 0 if not constant headache

Average pain: (circle **ONE** number) no pain 0 1 2 3 4 5 6 7 8 9 10 most pain ever

My headaches are:  Continuous  Episodic Headache onset is:  Gradual  Abrupt  
(check **ONE**) (constant pain) (no pain at times) (check **ONE**)

Since onset, pain is:  Same  Better  Worse If worse, increased:  Frequency  Severity  Duration

Worst time of day: (check **one**)  Awakening  Morning  Afternoon  Evening  Night  Sleeping

Worse as the day progresses?  Yes  No Better as the day progresses?  Yes  No

Worse on workdays?  Yes  No Affected by weather?  Yes  No

Interrupt sleep?  Yes  No Family members with headaches?  Yes  No

Worse with exercise?  Yes  No Caused by certain food or drink?  Yes  No

What makes headaches worse?

What makes headaches better?

What is headache's daily, weekly, or monthly pattern?

Describe light, balance, or sound sensitivity with the headaches.

List all medications taken for headache (current or historical):

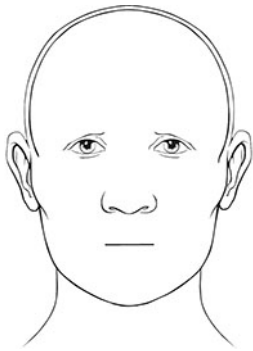
## TEMPOROMANDIBULAR JOINT NOISE

**Describe when the noise began, how & when it has changed, and present observations.**

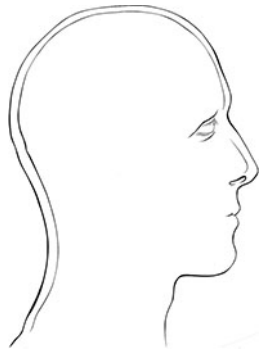
| <input type="checkbox"/> None Ever | Initial Onset  |                                |   | Progression  |                                |   | Current Condition  |                                |   |
|------------------------------------|--|--------------------------------|---|--|--------------------------------|---|--|--------------------------------|---|
| Change Date:                       | Month & Year:  |                                |   | Month & Year:  |                                |   | Month & Year:  |                                |   |
|                                    | Sound  |                                | Pain?   | Sound  |                                | Pain?   | Sound  |                                | Pain?   |
| Right Only                         | <input type="checkbox"/> Pop   | <input type="checkbox"/> Click | <input type="checkbox"/> Yes  | <input type="checkbox"/> Pop   | <input type="checkbox"/> Click | <input type="checkbox"/> Yes  | <input type="checkbox"/> Pop   | <input type="checkbox"/> Click | <input type="checkbox"/> Yes  |
| Left Only                          | <input type="checkbox"/> Pop   | <input type="checkbox"/> Click | <input type="checkbox"/> Yes  | <input type="checkbox"/> Pop   | <input type="checkbox"/> Click | <input type="checkbox"/> Yes  | <input type="checkbox"/> Pop   | <input type="checkbox"/> Click | <input type="checkbox"/> Yes  |
| Both Sides                         | <input type="checkbox"/> Pop   | <input type="checkbox"/> Click | <input type="checkbox"/> Yes  | <input type="checkbox"/> Pop   | <input type="checkbox"/> Click | <input type="checkbox"/> Yes  | <input type="checkbox"/> Pop   | <input type="checkbox"/> Click | <input type="checkbox"/> Yes  |
| How often it occurs?               | <input type="checkbox"/> Occasional <input type="checkbox"/> Intermittent    |                                | <input type="checkbox"/> Constant                                     | <input type="checkbox"/> Occasional <input type="checkbox"/> Intermittent    |                                | <input type="checkbox"/> Constant                                     | <input type="checkbox"/> Occasional <input type="checkbox"/> Intermittent    |                                | <input type="checkbox"/> Constant                                     |
| It can be heard                    | <input type="checkbox"/> Only by me <input type="checkbox"/> Across room     |                                | <input type="checkbox"/> Others nearby                                | <input type="checkbox"/> Only by me <input type="checkbox"/> Across room     |                                | <input type="checkbox"/> Others nearby                                | <input type="checkbox"/> Only by me <input type="checkbox"/> Across room     |                                | <input type="checkbox"/> Others nearby                                |
| When does noise occur?             | <input type="checkbox"/> Early opening <input type="checkbox"/> Wide opening |                                | <input type="checkbox"/> Mid-opening <input type="checkbox"/> Closing | <input type="checkbox"/> Early opening <input type="checkbox"/> Wide opening |                                | <input type="checkbox"/> Mid-opening <input type="checkbox"/> Closing | <input type="checkbox"/> Early opening <input type="checkbox"/> Wide opening |                                | <input type="checkbox"/> Mid-opening <input type="checkbox"/> Closing |

## PAIN LOCATION

On the diagrams below, outline the entire affected area(s) and shade in those area(s).



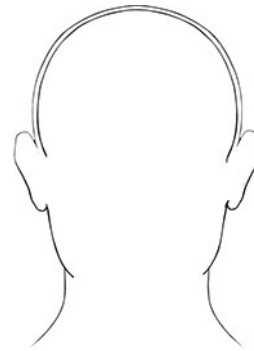
Front



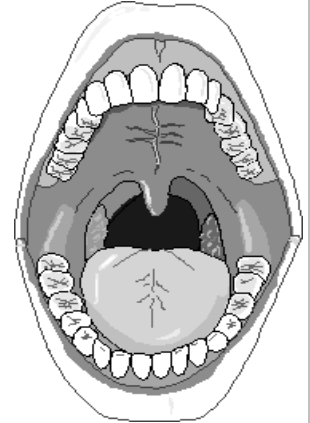
Right



Left



Back



## RESTRICTION IN OPENING

|                              |                          |                          |                          |                          |                          |                          |                          |                                |                          |            |
|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|------------|
| Normal Opening               | <input type="checkbox"/> | 3 fingers                | <input type="checkbox"/> | 3.5 fingers              | <input type="checkbox"/> | 4 fingers                | <input type="checkbox"/> | I Have No Restricted Opening   |                          |            |
| Restricted Opening           | <input type="checkbox"/> | 1 fingers                | <input type="checkbox"/> | 1.5 fingers              | <input type="checkbox"/> | 2 fingers                | <input type="checkbox"/> | <b>Restriction Start Date:</b> |                          |            |
| Which side feels restricted? | <input type="checkbox"/> | Right                    | <input type="checkbox"/> | Left                     | Feels like:              |                          | <input type="checkbox"/> | Tight rubber band or           | <input type="checkbox"/> | Stuck door |
| Episodes #                   | per                      | <input type="checkbox"/> | Day                      | <input type="checkbox"/> | Week                     | <input type="checkbox"/> | Month                    | <b>Constant since (Date):</b>  |                          |            |

## CENTRAL NERVOUS SYSTEM

|   |                          |      |                          |       |
|---|--------------------------|------|--------------------------|-------|
| Are you feeling depressed?  | <input type="checkbox"/> | Yes  | <input type="checkbox"/> | No    |
| Are you feeling anxious?  | <input type="checkbox"/> | Yes  | <input type="checkbox"/> | No    |
| Does an increase in stress, anxiety, or depression make your pain worse?                | <input type="checkbox"/> | Yes  | <input type="checkbox"/> | No    |
| How would you describe yourself?  | <input type="checkbox"/> | Calm | <input type="checkbox"/> | Tense |
| Have you ever been under care for depression, anxiety, or high stress?                  | <input type="checkbox"/> | Yes  | <input type="checkbox"/> | No    |
| Have you ever taken any antidepressant or anti-anxiety medication ( <i>SSRI, TCA</i> )? | <input type="checkbox"/> | Yes  | <input type="checkbox"/> | No    |
| Have you ever sought counseling, psychotherapy, or psychiatry?                          | <input type="checkbox"/> | Yes  | <input type="checkbox"/> | No    |

Briefly explain all "yes" answers:

Check any of the following habits you have or have had:

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Nail biting    | <input type="checkbox"/> Pencil biting   | <input type="checkbox"/> Eyebrow picking |
| <input type="checkbox"/> Hand clenching | <input type="checkbox"/> Cheek biting    | <input type="checkbox"/> Lip biting      |
| <input type="checkbox"/> Hair twirling  | <input type="checkbox"/> Cuticle picking |  |

What aggravates, stimulates, or initiates your depression, anxiety, or stress?

What are your frustrations, concerns, and problems with chronic pain, chronic pain therapy, or any aspect of your journey up to the present?

What percentage of relief would be acceptable from treatment? %

What do you expect by including Raleigh Facial Pain Center on your health management team?

## CARDIOVASCULAR HEALTH

How many days do you exercise during an average week?    0    1    2    3    4    5    6    7

|                   |             |                       |
|-------------------|-------------|-----------------------|
| Type of exercise: | Time spent: | Distance/repetitions: |
|-------------------|-------------|-----------------------|

|         |      |         |     |     |        |     |      |
|---------|------|---------|-----|-----|--------|-----|------|
| Weight: | lbs. | Height: | ft. | in. | Waist: | in. | BMI: |
|---------|------|---------|-----|-----|--------|-----|------|

## SLEEP

Rate your overall sleep quality:      poor    0    1    2    3    4    5    6    7    8    9    10    great

|  |   |         |       |
|--|---|---------|-------|
| What time do you normally go to bed?   | Bedtime varies by ( <i>number</i> )       | minutes | hours |
| Are you refreshed after sleeping? <input type="checkbox"/> Yes <input type="checkbox"/> No   | How long has your sleep been unrefreshed? |         |       |
| How many hours nightly do you devote to sleep?   | How many hours do you actually sleep?     |         |       |
| Do you have trouble falling asleep? <input type="checkbox"/> Yes <input type="checkbox"/> No   | How long to fall asleep?                  | minutes | hours |
| Do you have trouble maintaining sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Number of awakenings per night:           |         |       |
| Do you awaken due to pain? <input type="checkbox"/> Yes <input type="checkbox"/> No  | How long to resume sleep?                 | minutes | hours |
| What medications have you taken (now or in the past) to improve sleep?   |   |         |       |
| If you ever had a sleep study done, please enter year & results:   |   |         |       |
| Check all that apply: <input type="checkbox"/> Obstructed breathing <input type="checkbox"/> Apnea <input type="checkbox"/> Frequent dreams <input type="checkbox"/> Snoring |   |         |       |

## LIFE EVENTS

**List the dates (years) that the following events have happened in your life.**

|                                     |  |                                       |  |  |                                    |                                   |
|-------------------------------------|--|---------------------------------------|--|--|------------------------------------|-----------------------------------|
| Living Together (yrs)               | Marriages (yr)    1 <sup>st</sup> :          | 2 <sup>nd</sup> :                     | Divorces (yr)    1 <sup>st</sup> :         | 2 <sup>nd</sup> :                            |                                    |                                   |
| Job Dissatisfaction                 | Job Changes                                  |                                       | Job Termination                            |  |                                    |                                   |
| Family Problems                     | Children's Issues                            |                                       | Financial Trouble                          |  |                                    |                                   |
| School Problems                     | Moving/Relocation                            |                                       | Serious Illness                            |  |                                    |                                   |
| Dependency: Drug                    | Alcohol                                      |                                       | Chemical                                   |  |                                    |                                   |
| Abuse: Sexual                       | Emotional                                    |                                       | Physical                                   |  |                                    |                                   |
| Current relationship:               | <input type="checkbox"/> Single              | <input type="checkbox"/> Married      | <input type="checkbox"/> Significant other | <input type="checkbox"/> Engaged             | <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced |
| With whom do you live:              | <input type="checkbox"/> Alone               | <input type="checkbox"/> Spouse       | <input type="checkbox"/> Significant other | <input type="checkbox"/> Roommate            | <input type="checkbox"/> Children  | <input type="checkbox"/> Parents  |
| If married, describe your marriage: | <input type="checkbox"/> Excellent           | <input type="checkbox"/> Satisfactory | <input type="checkbox"/> Unsatisfactory    | <input type="checkbox"/> Very unsatisfactory |                                    |                                   |
| Explanation:                        | Do you consider yourself a spiritual person? |                                       |  | <input type="checkbox"/> Yes                 | <input type="checkbox"/> No        |                                   |

For the following, indicate relationship and year(s) with regard to Close Relatives and/or Friends:

|                 |       |
|-----------------|-------|
| Serious Illness | Death |
|-----------------|-------|

## MEDICATIONS

**List all medications you are taking for any reason. Place C beside drugs covered by opioid contract.**

| Name | Dose | Time Taken | Reason | Prescriber |
|------|------|------------|--------|------------|
|      |      |            |        |            |
|      |      |            |        |            |
|      |      |            |        |            |
|      |      |            |        |            |
|      |      |            |        |            |
|      |      |            |        |            |
|      |      |            |        |            |
|      |      |            |        |            |
|      |      |            |        |            |
|      |      |            |        |            |

Describe any unusual reactions or allergies to **ANY** medications:

## PAIN DESCRIPTION

Some of the words below may describe your condition. **Circle each and every word that describes your pain/dysfunction/condition.** Leave out any category that does not apply.

|   |   |   |   |   |
|---|---|---|---|---|
| <b>1</b> Flickering<br>Quivering<br>Pulsing<br>Throbbing<br>Beating<br>Pounding | <b>2</b> Jumping<br>Flashing<br>Shooting                    | <b>3</b> Prickling<br>Boring<br>Drilling<br>Stabbing<br>Lancinating | <b>4</b> Sharp<br>Cutting<br>Lacerating             | <b>5</b> Pinching<br>Pressing<br>Gnawing<br>Cramping<br>Crushing      |
| <b>6</b> Tugging<br>Pulling<br>Wrenching  | <b>7</b> Hot<br>Burning<br>Scalding<br>Searing              | <b>8</b> Tingling<br>Itchy<br>Smarting<br>Stinging                  | <b>9</b> Dull<br>Sore<br>Hurting<br>Aching<br>Heavy | <b>10</b> Tender<br>Taut<br>Rasping<br>Splitting                      |
| <b>11</b> Tiring<br>Exhausting  | <b>12</b> Sickening<br>Suffocating                          | <b>13</b> Fearful<br>Frightful<br>Terrifying<br>Vicious             | <b>14</b> Punishing<br>Grueling<br>Cruel            | <b>15</b> Wretched<br>Blinding  |
| <b>16</b> Annoying<br>Troublesome<br>Miserable<br>Intense<br>Unbearable         | <b>17</b> Spreading<br>Radiating<br>Penetrating<br>Piercing | <b>18</b> Tight<br>Numb<br>Drawn<br>Squeezing<br>Tearing            | <b>19</b> Cool<br>Cold<br>Freezing                  | <b>20</b> Nagging<br>Nauseating<br>Agonizing<br>Dreadful<br>Torturing |

What is your pain threshold (ability to tolerate pain)? (check one)

Low

Medium

High

## MEDICATIONS TAKEN FOR CONDITION

Please circle any medications you have taken for the problems for which we are seeing you.

|               |                 |           |             |              |               |            |             |
|---------------|-----------------|-----------|-------------|--------------|---------------|------------|-------------|
| Abilify       | Benadryl        | Dalmane   | Fiorinal    | Lithium      | Norgesic      | Prozac     | Tramadol    |
| Acetaminophen | Bextra          | Darvocet  | Flexeril    | Lodine       | Norpramin     | Relafen    | Tranxene    |
| Acyclovir     | Boniva          | Darvon    | Flonase     | Lorazepam    | Oxaprozin     | Remeron    | Trazodone   |
| Advil         | Bufferin        | Daypro    | Fluoxetine  | Lorcet       | Oxy IR        | Requip     | Trileptol   |
| Aleve         | BuSpar          | Decadron  | Fosamax     | Lortab       | Oxcarbazepine | Restoril   | Tylenol     |
| Alprazolam    | Butazolidin     | Demerol   | Frova       | Lunesta      | Oxycodone     | Robaxin    | Ultram      |
| Ambien        | Butulium        | Depakote  | Geodon      | Lyrica       | Oxycontin     | Sansert    | Valium      |
| Amerge        | Cafergot        | Deseryl   | Halcion     | Maxalt       | Pamelor       | Savella    | Venlafaxine |
| Amitriptyline | Calan           | DHE 45    | Haldol      | Meclizine    | Parnate       | Serax      | Verapamil   |
| Anacin        | Carbamazepine   | Dilantin  | Humira      | Meperidine   | Paroxetine    | Seroquel   | Vicodin     |
| Anaprox       | Celebrex        | Dolobid   | Hydrocodone | Meprobamate  | Paxil         | Serzone    | Vioxx       |
| Antibiotics   | Celexa          | Doxepin   | Ibuprofen   | Methotrexate | Percocet      | Sinequan   | Voltaren    |
| Aredia        | Clonazepam      | Drixoral  | Imipramine  | Midrin       | Percodan      | Skelaxin   | Wellbutrin  |
| Arthrotec     | Codeine         | Duradrin  | Imitrex     | Mobic        | Percogesic    | Soma       | Xanax       |
| Ascriptin     | Compazine       | Effexor   | Inderal     | Nabumetone   | Periactin     | Tavist     | Zanaflex    |
| Aspirin       | Cortisone       | Elavil    | Indocin     | Naprosyn     | Phenaphen     | Tegretol   | Zoloft      |
| Ativan        | Citalopram      | Empirin   | Klonopin    | Nardil       | Phenytoin     | Tizanidine | Zolpidem    |
| Axert         | Cyclobenzaprine | Equagesic | Lamictal    | Nasacort     | Prednisone    | Tofranil   | Zomida      |
| Baclofen      | Cyclospasmol    | Excedrin  | Lexapro     | Neurontin    | Propoxphene   | Topamax    | Zomig       |
| Beconase      | Cymbalta        | Fioricet  | Librium     | Norflex      | Provigil      | Toradol    | Zyprexa     |

Others: (list)

## GENERAL MEDICAL HISTORY

**Circle pathology and indicate year of onset. Give details of treatments in space provided below.  
Add a page if necessary.**

|                                      |  |  |
|--------------------------------------|--|--|
| AIDS                                 | Diabetes                                 | Pacemaker/Internal Defibrillator         |
| Alcoholism                           | Easy Bleeding                            | Pregnancy Complications                  |
| Allergy (Adhesives)                  | Epilepsy/Seizure Disorder                | Prolonged Bleeding                       |
| Allergy (Anesthesia)                 | Extreme Weight Changes (loss, gain)      | Psychiatric or Psychological Care        |
| Allergy (Environment)                | Fibromyalgia/Lupus                       | Radiation Therapy                        |
| Allergy (Latex)                      | Frequent Mouth Ulcers                    | Respiratory Conditions/Breathing Trouble |
| Allergy (Medications)                | Genital Problems                         | Rheumatic Fever                          |
| Alzheimer's Disease/Dementia         | Head or Neck Injury/Trauma               | Ringing Ears/Tinnitus                    |
| Anemia                               | Heart Murmur                             | Scarlet Fever                            |
| Arthritis                            | Heart Surgery                            | Sickle Cell Disease                      |
| Artificial Joints                    | Hepatitis                                | Sinus Problems                           |
| Asthma                               | Herpes (any location)                    | Skin Moles/Growths/Lesions               |
| Bipolar Disorder                     | HIV Positive                             | Skin Rashes                              |
| Birth Control Pills/Shots/Patches    | Hyperlipidemia                           | Stomach Ulcers                           |
| Bowel Problems                       | Hypertension/High Blood Pressure         | Stomach/Digestive Problems               |
| Cardiac Conditions/Heart Trouble     | Hypoglycemia                             | Stroke                                   |
| Circulatory Problems                 | Joint Noises                             | Thyroid Problems (hyper, hypo, tumor)    |
| Cirrhosis of Liver                   | Kidney Conditions                        | Tonsillitis                              |
| Constipation                         | Mononucleosis                            | Tuberculosis                             |
| COPD/Emphysema                       | Nerve Problems (viral, trauma, surgical) | Tumors/Growths/Cancers                   |
| Dependency (drug, alcohol, chemical) | Osteoporosis                             | Vertigo/Dizziness                        |

Treatment Details for Circled Conditions:

### List hospitalizations or surgeries (of any type)

| Date | Reason | Treatment |
|------|--------|-----------|
|      |        |           |
|      |        |           |
|      |        |           |
|      |        |           |

**Recent Medical Care: List conditions *other than orofacial* for which you sought treatment in the past two years.**

**List problems or diseases affecting any generation of your family: (*condition & relationship*)**

|  |
|--|
|  |
|--|

## HEALTHCARE PROVIDER HISTORY

Please check the healthcare providers you have seen or consulted for your present pain.

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Acupuncturist    | <input type="checkbox"/> ER Hospital           | <input type="checkbox"/> Ophthalmologist       | <input type="checkbox"/> Prosthodontist          |
| <input type="checkbox"/> Allergist        | <input type="checkbox"/> Family Physician      | <input type="checkbox"/> Oral Surgeon          | <input type="checkbox"/> Psychiatrist            |
| <input type="checkbox"/> Anesthesiologist | <input type="checkbox"/> Gynecologist          | <input type="checkbox"/> Orthodontist          | <input type="checkbox"/> Psychologist            |
| <input type="checkbox"/> Chiropractor     | <input type="checkbox"/> Healing touch         | <input type="checkbox"/> Orthopedic surgeon    | <input type="checkbox"/> Psychotherapist         |
| <input type="checkbox"/> Craniosacral     | <input type="checkbox"/> Internist             | <input type="checkbox"/> Pain/Rehab Center     | <input type="checkbox"/> Rheumatologist          |
| <input type="checkbox"/> Dentist          | <input type="checkbox"/> Massage therapist     | <input type="checkbox"/> Pediatric Neurologist | <input type="checkbox"/> Surgeon                 |
| <input type="checkbox"/> Dermatologist    | <input type="checkbox"/> Neurologist           | <input type="checkbox"/> Pediatrician          | <input type="checkbox"/> Thai Chi, Yoga          |
| <input type="checkbox"/> Endocrinologist  | <input type="checkbox"/> Neuromuscular therapy | <input type="checkbox"/> Periodontist          | <input type="checkbox"/> Trigger Point therapist |
| <input type="checkbox"/> Endodontist      | <input type="checkbox"/> Neurosurgeon          | <input type="checkbox"/> Physical Therapist    | <input type="checkbox"/> Urgent Care             |
| <input type="checkbox"/> ENT Physician    |  |  |  |

List all provider names:

## DENTAL HEALTH - PARAFUNCTION

- |   |  |  |   |
|---|--|--|---|
| Do you feel you clench (hold your teeth together)?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, when?                              | <input type="checkbox"/> Day <input type="checkbox"/> Night |
| Do you grind your teeth at night?   |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Do you routinely hold anything in-between your teeth (pencil, pen, pipe, cigar, etc)? |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Do you feel that clenching or grinding your teeth contributes to your pain?           |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Are any of your teeth worn, flattened, showing dentin, or have shiny areas?           |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Has a dentist ever mentioned that you grind or clench your teeth?                     |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Do you have hard bony lumps?  | <input type="checkbox"/> in the roof of your mouth       | <input type="checkbox"/> under your tongue | <input type="checkbox"/> No                                 |
| Do you have hot or cold sensitivity to your teeth - now or in the past?               |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Have your gums receded over the years around any teeth?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | If so, where?                              |   |
| Have you had your wisdom teeth removed?   |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Have you ever broken, chipped, or cracked a filling, crown, or tooth?                 |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No    |
| Dates of Orthodontic Treatment:   | to   | and  | to  |

## ORAL APPLIANCE

**If you have an oral appliance, bring it to your exam.**

Date First Appliance Acquired:

- Mark all that apply:
- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Splint<br>(hard-cover all teeth) | <input type="checkbox"/> Deprogrammer<br>(NTI-anterior button) | <input type="checkbox"/> Repositioning<br>(move jaw forward) | <input type="checkbox"/> Soft Nightguard<br>(bruxing, grinding) |
| <input type="checkbox"/> Upper                            | <input type="checkbox"/> Store Bought                          | <input type="checkbox"/> Hard                                | <input type="checkbox"/> Soft                                   |
| <input type="checkbox"/> Lower                            | <input type="checkbox"/> Professionally Made                   | <input type="checkbox"/> Hard outside, Soft inside           | <input type="checkbox"/> Full covers all teeth                  |
|   |  | <input type="checkbox"/> Partial-just posterior              | <input type="checkbox"/> Partial-just anterior                  |

Date Second Appliance Acquired:

- Mark all that apply:
- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Splint<br>(hard-cover all teeth) | <input type="checkbox"/> Deprogrammer<br>(NTI-anterior button) | <input type="checkbox"/> Repositioning<br>(move jaw forward) | <input type="checkbox"/> Soft Nightguard<br>(bruxing, grinding) |
| <input type="checkbox"/> Upper                            | <input type="checkbox"/> Store Bought                          | <input type="checkbox"/> Hard                                | <input type="checkbox"/> Soft                                   |
| <input type="checkbox"/> Lower                            | <input type="checkbox"/> Professionally Made                   | <input type="checkbox"/> Hard outside, Soft inside           | <input type="checkbox"/> Full covers all teeth                  |
|   |  | <input type="checkbox"/> Partial-just posterior              | <input type="checkbox"/> Partial-just anterior                  |

## NUTRITION

|   |  |  |  |
|---|--|--|--|
| Do you eat at least two balanced meals per day? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Has your current condition changed your eating habits? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you take a daily multivitamin?               | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how:   |  |
| Do you take any other supplements?              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any food sensitivities?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, list:                                   |  | If yes, list:  |  |
| Do you drink alcohol after 6 PM?                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you drink caffeine after 6 PM?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Indicate daily consumption of the following:

|                       |                 |                  |
|-----------------------|-----------------|------------------|
| Cups of Coffee        | Glasses of Soda | Glasses of Tea   |
| 12 ounce Beers        | Glasses of Wine | Ounces of Liquor |
| Servings of Chocolate | Cigarettes      | Chews of Tobacco |

## ERGONOMICS

|   |  |   |  |
|---|--|---|--|
| <b>Desktop</b> monitor height:                    | <input type="checkbox"/> Above eye level   | <input type="checkbox"/> At eye level   | <input type="checkbox"/> Below eye level   |
| Desktop monitor location:                         | <input type="checkbox"/> In front          | <input type="checkbox"/> To the right   | <input type="checkbox"/> To the left       |
| Desktop keyboard height:                          | <input type="checkbox"/> Above elbow level | <input type="checkbox"/> At elbow level | <input type="checkbox"/> Below elbow level |
| Number of hours at the desktop PC per day:        |  |   |  |
| <b>Laptop</b> normal height:                      | <input type="checkbox"/> Above elbow level | <input type="checkbox"/> At elbow level | <input type="checkbox"/> Below elbow level |
| Number of hours laptop used per day:              |  |   |  |
| <b>Tablet/E-reader/etc:</b>                       | <input type="checkbox"/> Above elbow level | <input type="checkbox"/> At elbow level | <input type="checkbox"/> Below elbow level |
| Number of hours Tablet/E-reader/etc used per day: |  |   |  |

## COMPENSATION ASPECTS

Will this care be involved to support legal action regarding your pain?  Yes  No

If yes, provide attorney's contact information:

## PATIENT SIGNATURE

I understand that honest answers to the questions on this form are important to my health and my medical care. I have answered all questions to the best of my ability. I verify that all information about my health, no matter how unrelated I think it may be, has been provided, including all positive or negative tests, images, examinations, medications, outcomes, and home remedies. **I verify the completeness of this form with my signature.**

|                             |                              |              |
|-----------------------------|------------------------------|--------------|
| <i>Patient's signature:</i> | <i>Printed Patient Name:</i> | <i>Date:</i> |
|-----------------------------|------------------------------|--------------|