

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: (indicate **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 schooldays? 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.**