

CONDITION DETAILS

Use a separate copy of this page for each pain, dysfunction, problem, or location.

Briefly define your child's condition – for example: "jaw pain", "face pain", "headache", "migraine", "neck pain", "clenching", "ear pain", etc. Be sure to tell us about **every problem** with your child's head and neck region. Do not leave out any head pain.

Condition: (*ONE per page*) **Priority:** (*circle #*) 1 2 3 4 5 6 7 8

Pain Occurs: (*check ONLY one*) Left side only Right side only Both sides Switches sides

Primary Location of Pain: **ONE BRIEF DESCRIPTOR** – EXAMPLE: Jaw, Temple, Neck, Tongue, Ear, Teeth, Forehead, Back of Head, Top of Head, Above Eyes, etc

What else do you notice when the pain occurs? Describe any additional pain locations that occur with or because of primary pain. For example: "Whenever my jaw hurts, I get an earache deep inside"

First date you noticed: **Describe original onset:**

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

Include Details:

Pain Levels: Average Severity (*check ONLY one*) 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

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

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

Pain worse as the day progresses? Yes No **Pain less as the day progresses?** Yes No

Is the pain worse on workdays? Yes No **Does weather affect the pain?** Yes No

Does pain interrupt sleep? Yes No **Any family members with same pain?** Yes No

What increases the pain? (*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 Menstrual cycle Other:

What decreases the pain? (*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: (*list names, dosage*)

Healthcare Providers who have treated: (*list name, specialty, treatment*)

What lifestyle changes have been made due to pain/dysfunction?