INTRODUCTION to CHRONIC PAIN
OR
DYSFUNCTION of the CHEWING SYSTEM

Welcome
We appreciate the opportunity to get to know you and your pain or jaw joint dysfunction. The team at Raleigh Facial Pain Center is dedicated to helping you achieve a better quality of life through interdisciplinary pain management. With over 30 years' experience treating and healing patients of all ages, we use our extensive knowledge and experience to seek and find the root cause of your pain. We then use an integrated multidisciplinary treatment approach to decrease your suffering. We utilize the latest scientific advances combined with highly trained healthcare professionals who share knowledge, skill, empathy and time with you.

Need to Understand Your Pain (Pre-exam questionnaire)
We begin our evaluation process by getting to know you and the pain or dysfunction you are experiencing. We spend quality time listening and learning. The pathologies that are presented to us do not have the visual diagnostic clues of common pains (broken leg=x-ray, green stuff in the nose=nasal scope): therefore, we have to ask extensive questions in our pre-examination questionnaire looking for every clue. We complete our understanding of your pain or dysfunction through the pain interview at the examination. Filling out the detailed questionnaire is a tedious process but one that is vital to helping us determine you pathology (pain or abnormal function). The better you communicate your history on this questionnaire, the quicker, and more thorough, the doctor can diagnose contributing pathologies, the less time the exam will take, and the less money your exam costs. *Please do not underestimate the need for information or understate the information requested. We must have the pre-examination questionnaire before the appointment is scheduled. In an effort to save you money,* we may ask you to review and further complete any sections of pre-examination questionnaire not completed with the enough detail.

You are the Expert on You (Pre-exam questionnaire)
You may think the need to know the patient behind the pain is just a catchy idea. If you understand chronic pain (recurring or continuous pain), you would know the multitude of contributing factors that affects pain such as depression, anxiety, medications, genetics, global pains (fibromyalgia, lupus, diabetes), negative thinking, poor sleep, excessive caffeine, poor posture, age, gender, level of pain, meaning of pain, etc. To successfully get to the root of the pain and any perpetuating factors, we must extract exacting and detailed information from you that can be related to the pain continuance. In order for us to prepare for your exam and to accurately diagnose your conditions, we need all the data related to each and every pain or dysfunction (can't open mouth wide) in the head, face and neck region.

Previous Records (Pre-exam questionnaire)
To assist you at remembering the details of any past care, please contact previous healthcare providers to request relevant medical andor dental records – no matter how old. This may include exam, clinical notes, lab results, imaging reports (MRI, CT, x-rays, ultrasound, panorex, etc). We need these records to prepare for your exam. **We will be happy to assist you in obtaining these records, but we need you to list the names and phone numbers (fax numbers if you know them) of all doctors seen for any head, face, jaw, neck, ear or mouth issues. *Please include orthodontists on this list.***

Exam Time
Please assist us at keeping healthcare costs down by arriving 15 minutes before your scheduled exam time on the first visit. Because we reserve this time with the doctor, we cannot adjust the appointment ending time if you arrive late. Your fee for quality time with the doctor is based on the amount time you have reserved with the doctor. You will be with the doctor for approximately one hour for the pain interview and clinical exam. Three banks of data (information) are collected at the examination: components of pain, evolution of pain, and the clinical examination. After you leave our office, we compile the information from the exam with your information, study the potential pain sources, review diagnoses, and prepare a management and treatment plan especially for you. Prior to leaving the initial exam, you will schedule the second visit (consult) in approximately one week, where we review your diagnoses with you, provide education regarding these diagnoses, map out a custom treatment plan, share information with your referring doctor, and project the expectations for your improved lifestyle.

Important Significant Other: It is important that anyone you deem as important and involved with your healthcare (spouse, sister, friend, child) attend the consult. The person that makes the financial and healthcare decisions in your family needs to attend the second appointment to understand what is involved to help you with pain reduction and/or improved jaw function. Please confer with these important people in your life prior to the exam to determine their availability.

Cost Examination
To thank the doctor for his time and knowledge, you will compensate the doctor $350 for the hour he spends listening and understanding your pain or jaw dysfunction and performing the clinical exam. By providing the details necessary, we are able to keep the cost of the examination to the minimum cost, but if the information provided on the pre-exam form is vague or poor detail we would be forced to increase the cost to $500 for the extra time needed to extract the information chairside. We accept many forms of payment (Visa, MasterCard, Discover, HAS cards, checks, cash, & CareCredit) for the doctor's time and knowledge. You may file for reimbursement with your insurance provider by using the forms we provide (CMS 1500). NC law requires that the insurance company respond to you in thirty days when using these forms. We will provide assistance with any insurance denial after you have exhausted the appeals process.

Consultation-Patient Education
We are best known for our ability to provide accurate diagnoses, to take the time to determine the root cause of the problem(s), provide patient education materials regarding the science of jaw pain and chewing system orthopedics and to construct and manage an excellent orthopedic appliance. The patient education materials are to provide proper education, based on science, regarding the causes of the pain pathology, review the joint muscle damage, and outline the patient's control of the damaging factors. By dedicated reading time at home, you save money by decreasing the one-on-one time with the doctor needed to reach an understanding of your conditions and management protocol. Each patient is unique and has specific needs and the consultation is to outline specific needs that need to be addressed to successfully manage the pain and equip you to obtain the needed healthcare. After you are fully aware of all the problems, causes, and solutions, we review the time, cost, and passion to getting better. In some cases, the diagnosis is half of the benefit to the patient because they have been to so many doctors without an understanding of the pathology.

Communications from Patients
Knowing that some of our patients will come to us with anger from past, severe negative thinking, irritability from the pain, or even psychosocial issues, we always expect proper adult communication. Any problems or concerns that arise in course of the examination, consultation, or implementation of orthopedic therapy are to be addressed with Dr. Yount in person. We are happy to provide a free consultation appointment for you to express your concerns and allow us time to hear and manage your concerns appropriately. We pledge our most valiant effort to correct any and all reasonable concerns. With this outlet for your concerns, you agree to not say unprofessional comments to others or post inappropriate comments on the internet without first addressing this method of arbitration. If you were to violate the patient doctor communication agreement, you will be liable for $10,000 for each violation plus legal fees and court cost.

Review of Instructions: **(we cannot diagnose without all the detailed information**)(we cannot keep costs down with limited information) (if we have to collect it chairside the cost may go up)

1) **Completely** fill out pre-examination questionnaire (do not leave any section blank)
2) Separate different headaches on separate headache forms
3) Detail all accidents and traumas on separate forms (under additional optional forms on website)
4) Time line or evolution of pain needs all important details and events
5) Obtain any records from previous doctors or dentists that may help in exam & diagnosis (or provide us with a thorough list and pertinent numbers so that we may assist you with obtaining prior records)
6) Sign the patient consent form (so that we may converse with your doctors)
7) Return completed pre-exam questionnaire and get scheduled for your orofacial pain exam
8) Mark your calendar for the date of examination (reserved time with doctor)
9) Arrive 15 minutes early for your appointment
10) Bring your insurance card and method of payment
11) Anticipate a minimum of one hour for the doctor to get to know you and your pain during the examination
12) Read "chronic pain" article on our webpage before your examination
13) Dedicate reading time for the pertinent educational articles for joint muscle pain
14) We do not accept changes to your examination reservation less than 3 business days in advance (business days are Monday – Thursday)
15) We accept credit cards, debit cards, HSA cards, checks, cash, CareCredit
16) Letter of medical necessity will be provided at the consultation (used to file insurance)

_____ _____ _____
Signature of Patient Printed Name of Patient Date

Office Use: Accepted by _____ Date _____

Raleigh Facial Pain Center

Keith A. Yount, DDS, MAGD
Diplomate, American Board of Orofacial Pain

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Phone: 919-781-6600
Fax: 919-781-6430

NEW PATIENT INFORMATION

PLEASE PRINT LEGIBLY

Patient Full Name:				❑ Male ❑ Female	
Nickname/Preferred Name:		Date of Birth:		Age:	
Social Security Number:		Drivers License Number/State:			
Marital Status: ❑ Single	❑ Engaged	❑ Married	❑ Separated	❑ Divorced	❑ Widowed
Home Address:		City/State:		ZIP Code:	
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Email:		
Employer or College:		Job Title or Degree Pursued:		Work Hours:	
Work Address:		City/State:		ZIP Code:	
Spouse Name:		Work Phone: ( )	Cell Phone: ( )		
Employer:		Job Title:		Work Hours:	
Work Address:		City/State:		ZIP Code:	
Children's Names and Ages:					
Additional Contact (***Required***)	Relationship	Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	

HEALTHCARE PROVIDERS INFORMATION

Who may we thank for referring you?		
Primary Care Physician:	Send reports to this provider? ❑ Yes ❑ No	Phone: ( )
Office Address:		
Date of Last Appointment:	Findings:	
Primary Dental Care Provider:		Phone: ( )
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: ❑ PPO ❑ HMO ❑ Open Access ❑ Self-Funded ❑ Supplemental ❑ Other (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 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. By seeking care, I assume financial responsibility for all charges and agree to pay my account in full at the time services are rendered.

Patient's signature:	***Printed Patient Name:***	***Date:***

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:	❑ Yes	❑ No	❑ Message	Number:
Cell Phone:	❑ Yes	❑ No	❑ Message	❑ Text
Work Phone:	❑ Yes	❑ No	❑ Message	Number:
Fax:	❑ Yes	❑ No		Number:
Email:	❑ Yes	❑ 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:

Primary Name:		Relationship:
Email address:		Phone-cell:
Secondary Name:	Phone:	Relationship:

Patient's signature:	***Printed Patient Name:***	***Date:***

Office Use Only

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

❑ Patient refused to sign ❑ Communication barriers prevented obtaining acknowledgement ❑ An emergency situation prohibited obtaining acknowledgement ❑ 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", "tongue", "mouth", "tooth"

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

First Pain Ever, 1st noticed: (Date) _____ | Describe below original onset (circumstance, events, time day onset):

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

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*) *Circle 0 if pain is not constant*	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 ❑ Ache ❑ Deep ❑ Superficial ❑ Burning ❑ Sharp
❑ Shooting ❑ Tingling ❑ Throbbing ❑ Crawling ❑ Other:

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

Episodic Pain comes and goes	**Constant**: Pain is constant, but pain level may change
Does pain come on: Fast Slow	Does constant pain increase: Fast Slow
Frequency of episodes: __/day __ week __ month	How often pain goes up __/day __/week __/month
How long pain lasts ___ seconds ___ minutes __ hours	How long is pain elevated? __ seconds __minutes __hours

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

Worse as the day progresses?	❑ Yes ❑ No	Pain come & go, then become constant	❑ Yes ❑ No
Worse on workdays?	❑ Yes ❑ No	Has the pain inc **freq, dura, intensity**	❑ Yes ❑ No
Does condition interrupt sleep?	❑ Yes ❑ No	Did you see doctor or dentist for pain?	❑ 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 ❑ Grinding-night ❑ Eating

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: (*treatments, medicine, therapy, length usage)*

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

List any and all providers seen for this pain condition, examinations, treatments (help, no help), images, family practice, dentist, specialist, test, blood work, injections, pain therapies, and list all home remedies

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 DISCOMFORT DETAILS

Provide requested information if you have, or *ever had*, neck discomfort or pain. 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 discomfort, pain, or trauma of any type. _____ (initial true for you)

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

First Noticed Even Mild: _____ | Describe 1st neck pain(time day, special circumstance, duration-intensity)

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*) *Circle* 0 *if not constant pain*	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

Definitions: **Episodes pain:** *pain comes & goes* **Constant pain:** *continuous pain w/ increases of 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 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	Pain come & go, then became constant	❑ Yes ❑ No
Worse on workdays?	❑ Yes ❑ No	Has the pain inc freq, dura, intensity?	❑ Yes ❑ No
Does condition interrupt sleep?	❑ Yes ❑ No	Have you seen any providers for neck?	❑ 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 ❑ Poor posture

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*)

List any and all providers seen for this condition, exam this pain, refer for pain, list all home remedies

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.**

EVOLUTION OF NECK, JAW, HEAD PAIN

We need to understand your pain or joint malfunction journey. ***The main objective is to record the order of all events.*** *Tell all when any of your symptoms occurred, when did jaw, neck or head pain start.* When did each symptom or area of symptom? How did each symptom change over time? What has been done to address the pain or jaw joint malfunction. What are the results of each treatment, drug, or therapy. This evolution or time line MUST include every clinician consulted, all diagnostics test, every related event, all traumas, and all therapies with results. Being detailed-thorough-informative will save you money. Do your best to provide all details. Copy & **Use as an additional page if necessary.**

Date	Event	Outcome, Notes
1999-01	Ortho treatment followed by retainers	Dr Barney Rubble, cross bite, 2 upper molars extracted
May 2003	All 4 wisdom teeth extracted	Dr Wiley Coyote oral surgeon
July 2005	Right jaw started popping	No pain, noted with gum chewing
January 5, 2007	Knee surgery, locked jaw upon awakening	Right side stuck, pain and loud pop when forced
March 2008	Restricted opening every 2-3 weeks	Dentist Greg Brady referred to Dr Yount
Month-Year	**Dates: soft diet, gum chew,**	**Doctor Name-Specialty-Purpose-Treatment**
DATE	**EVENT**	**OUTCOME, NOTES**

Did you list **all** changes or progression in symptoms?	❑ Yes	❑ No
Did you list **all** doctors seen?	❑ Yes	❑ No
Did you list **all** motor vehicle collisions and other traumas?	❑ Yes	❑ No
Did you list **all** treatments received for **each pain**?	❑ Yes	❑ No

HEADACHE HISTORY (COPY PAGE FOR 2ND OR 3RD HEADACHE)****

Report ALL HEADACHE LOCATIONS you have EVER HAD, no matter how minor, infrequent, or in the past.
Describe ONE & ONLY ONE headache type &/or location per page. _____ (initial if NO HA, ever)

Have you ever had headache? ❑ 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												
Date **1st headache** -even mild **Date(need answer):_____** **Right:___ Left ___, Switch side __**												
Do you have warning (visual) before headache? ❑ No ❑ Yes Describe:												
Is headache associated with another event, condition, or circumstance? ❑ No ❑ Yes												
Type of pain: (*check all that apply*) ❑ Dull ❑ Sharp ❑ Deep ❑ Superficial ❑ Burning ❑ Aching ❑ Shooting ❑ Tingling ❑ Throbbing ❑ Crawling ❑ Other: _____												
Duration of headache: (*enter number in right time*): ____ 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*) Circle 0 if not constant headache	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

My headaches are: (*check **ONE***) ❑ Continuous (constant pain) ❑ Episodic (no pain at times)	Headache onset is: (*check **ONE***) ❑ Gradual ❑ Abrupt
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 on workdays? ❑ Yes ❑ No	Affected by weather? ❑ Yes ❑ No
Interrupt sleep? ❑ Yes ❑ No	Family members with headaches? ❑ Yes ❑ No
What makes this headache worse?	
What makes this headache better?	
What is this headache's daily, weekly, or monthly pattern?	
Describe light, balance, or sound sensitivity with this headache:	
List all medications ever taken or currently taking for this headache (indicate if it reduces headache, eliminates headache, or did not work): _____	

JAW JOINT NOISE

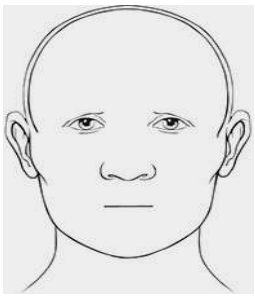
Describe when the noise began, how & when it has changed, and present TMJ noises.

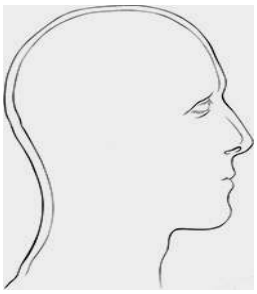
Be specific which joint started click 1st ❑ Rt ❑ Lt	Tell about 1st time- remember hearing? ❑ Yes ❑ No
Make sure year the click started is entered? (yellow box) ❑ Yes ❑ No	Did sound change? For example, click to pop or gravelly sound. ❑ Yes ❑ No

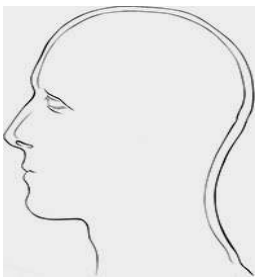
No TMJ Noise	**Initial Onset**			**Progression-Change**			**Current Noise**		
Ever Int_____	**Month & Year: _____/_____**			**Month & Year: _____/_____**			**Month & Year: _____/_____**		
	Sound		**No pain**	**Sound**		**Pain?**	**Sound**		**Pain?**
Right Only	❑ Pop	❑ Click	❑	❑ Pop	❑ Click	❑ Yes	❑ gravel	❑ Click	❑ Yes
Left Only	❑ Pop	❑ Click	❑	❑ Pop	❑ Click	❑ Yes	❑ gravel	❑ Click	❑ Yes
Both Sides	❑ Pop	❑ Click	❑	❑ Pop	❑ Click	❑ Yes	❑ gravel	❑ Click	❑ Yes
How often occurs (Frequency)	❑ Intermittent ❑ frequent ❑ On all open			❑ Intermittent ❑ most of time ❑ on all open			❑Intermittent ❑ most time ❑ on all open		
It can be heard (Loudness)	❑ Only by me ❑ Others nearby ❑ Across room			❑ Only by me ❑ Others nearby ❑ Across room			❑ Only by me ❑ Others nearby ❑ Across room		

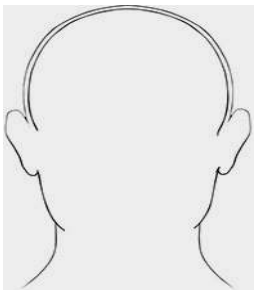
PAIN LOCATION FOR HEAD, NECK, JAW, TOOTH, GUM

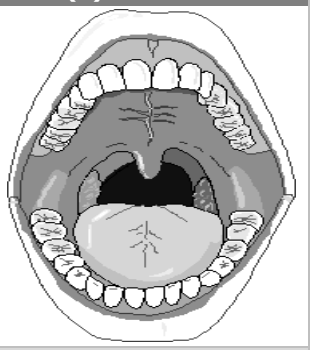
On the diagrams below, outline the affected area(s) and shade in those area(s).


Front


Right


Left


Back



RESTRICTED OPENING (CAN'T OPEN ALL THE WAY)

Normal Opening	❑ 3 fingers	❑ 3.5 fingers	❑ 4 fingers	❑ **Never Had Restricted Opening**	**Initials:_____**
1st Restricted Opening	❑ 1 fingers	❑ 1.5 fingers	❑ 2 fingers	**Date of 1st Restriction: _____**	
Which side feels restricted?	❑ Right	❑ Left	Feels like:	❑ Overstretched	❑ Stuck/Blocked
Episodes Per week___	Month____	Duration___	**Pain Y N**	**Locked & stayed locked (Date):_____**	
Gentle Man Force open	Manipulate	_____	(Circle one)	**What were you doing on 1st RO_____**	

CENTRAL NERVOUS SYSTEM

How would you describe yourself? Clarify & detail: Use your term _____ ❑ Calm ❑ Tense

Have you experienced: Stress ❑ Yes ❑ No Anxiety ❑ Yes ❑ No Depression ❑ Yes ❑ No

Does an increase in stress, anxiety, and/or depression make your pain worse? ❑ Yes ❑ No

Have you ever been under care for depression, anxiety, or high stress? ❑ Yes ❑ No

Have you ever taken any antidepressant or anti-anxiety medication (*SSRI, TCA*)? ❑ Yes ❑ No

Have you ever sought counseling, psychotherapy, or psychiatry? ❑ Yes ❑ No

Explain all "yes" answers: (dates, doctor name, tx or counseling, meds, duration med, side effects meds, benefit)

Check any of the following habits you have or have had: ❑ Nail biting ❑ Pencil biting ❑ Eyebrow picking ❑ Hand clenching ❑ Cheek biting ❑ Lip biting ❑ Hair twirling ❑ Cuticle picking

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

What are your frustrations, concerns, or problems with chronic pain, chronic pain therapy, or any aspect of your pain journey?

What percentage of relief would be acceptable from treatment? _____%

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

EXERCISE OR CARDIOVASCULAR THERAPY

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

Exercise Type: walk run treadmill swim bike	Time spent:	Distance:	
Weight: lbs.	Height: ft. in.	Waist: in.	Other Exercise:

COMPUTER ERGONOMICS (repeat for tablets, pads, or phones)

Monitor height ❑ above ❑ at ❑ below eye level	Monitor location ❑ in front ❑ to right ❑ to left
Keyboard ❑ above ❑ at ❑ below elbows	Average number of hours per day:

SLEEP BEFORE MEDS (COPY SECTION FOR PERIODS TAKING SLEEP MEDS)

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 (*number*)	minutes	hours
Are you refreshed after sleeping? ❑ Yes ❑ 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? ❑ Yes ❑ No	How long to fall asleep?	minutes	hours
Do you have trouble maintaining sleep? ❑ Yes ❑ No	Number of awakenings per night:		
Do you awaken due to pain? ❑ Yes ❑ 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, AHI, CPAP, Sleep appliance, Med:

Check all that apply: ❑ Obstructed breathing ❑ Apnea ❑ Frequent dreams ❑ Snoring

LIFE EVENTS

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

Living Together (yrs)	Marriages (yr) 1st: 2nd:	Divorces (yr) 1st: 2nd:
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: ❑ Single ❑ Married ❑ Significant other ❑ Engaged ❑ Separated ❑ Divorced ❑ Widowed

With whom do you live: ❑ Alone ❑ Spouse ❑ Significant other ❑ Roommate ❑ Children ❑ Parents

If married, describe your marriage: ❑ Excellent ❑ Satisfactory ❑ Unsatisfactory ❑ Very unsatisfactory

Explanation: | Do you consider yourself a spiritual person? ❑ Yes ❑ No

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

Serious Illness	Death

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

Mother (_____) Mother's mother (_____) Mother's father (_____)
Father (_____) Father's mother (_____) Father's father (_____)
Sibling (_____) Sibling (_____) Sibling (_____) Other (_____)

MEDICATIONS

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

Name	Dose	Time Taken	Reason	Prescriber

CONDITION DESCRIPTORS

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.

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

What is your pain threshold (ability to tolerate pain)? (*check only 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	Bupropion	Decadron	Fluconazole	Lioresal	Neurontin	Provigil	Topamax
Acetaminophen	Buspirone	Demerol	Flexeril	Lithium	Norflex	Prozac	Toradol
Acyclovir	BuSpar	Depakote	Flonase	Lodine	Norgesic	Relafen	Tramadol
Advil	Butazolodin	Deseryl	Fluoxetine	Lorazepam	Norpramin	Remeron	Tranxene
Aleve	Butulinum	Desipramine	Fosamax	Lorcet	Oxaprozin	Requip	Trazadone
Alprazolam	Cafergot	DHE 45	Frova	Lortab	Oxy IR	Restoril	Trileptal
Ambien	Calan	Diazepam	Frovatriptan	Lunesta	Oxcarbazepine	Rizatriptan	Tylenol
Amerge	Carbamazepine	Diclofenac	Gabapentin	Lyrica	Oxycodone	Robaxin	Ultracet
Amitriptyline	Carisoprodol	Dilantin	Geodon	Maxalt	Oxycontin	Rofecoxib	Ultram
Anacin	Celebrex	DPHydramine	Gralise	Meclizine	Pamelor	Sansert	Valium
Anaprox	Celexa	Dolobid	Halcion	Meloxicam	Parafon Forte	Savella	Valdecoxib
Antibiotics	Chlorazine	Doxepin	Haldol	Meperidine	Parnate	Serax	Valproxic acid
Aredia	Clonazepam	Drixoral	Humira	Meprobamate	Paroxetine	Sertaline	Venlafaxine
Arthrotec	Codeine	Duloxetine	Hydrocodone	Methocarbamol	Paxil	Seroquel	Verapamil
Ascriptin	Compazine	Duradrin	Ibuprofen	Methotrexate	Pentazocine	Serzone	Vicoprofen
Aspirin	Cortisone	Effexor	Imipramine	Microstatin	Percocet	Sinequan	Vicodin
Ativan	Citalopram	Elavil	Imitrex	Midrin	Percodan	Skelaxin	Vioxx
Axert	Cyclobenzaprine	Empirin	Inderal	Mobic	Percogesic	Soma	Voltaren
Baclofen	Cyclospasmol	Equagesic	Indocin	Nabumetone	Periactin	Sonata	Wellbutrin
Beconase	Cyproheptadine	Eszopiclone	Indomethacin	Naprosyn	Phenaphen	Sumatriptan	Xanax
Belsomra Benadryl	Cymbalta Dalmane	Escitalopram Excedrin	Ketaprofen Klonopin	Nardil Naratriptan	Phenytoin Prednisone	Tavist Tegretol	Zanaflex Zaleplon
Bextra	Darvocet	Fioricet	Lamictal	Nasacort	Pregablin	Temazepam	Zoloft
Boniva	Darvon	Fiorinal	Lexapro	Nefazondone	Propoxphene	Tizanidine	Zolpidem
Bufferin	Daypro				Propranolol	Tofranil	Zolmitriptan
						Topiramate	

DESCRIBE ANY ALLERGIES OR UNUSUAL REACTIONS TO ANY MEDICTIONS

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 (sensitivities)	Ear	Prolonged Bleeding
Allergy (Adhesives)	Epilepsy/Seizure Disorder	Psychiatric Care
Allergy (Anesthesia)	Extreme Weight Changes (loss, gain)	Psychological (Counseling)
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

Details: Medical History:1) _____

2) _____

3) _____

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.

HEALTHCARE PROVIDER SEEN FOR ANY HEAD OR NECK PAIN

Please circle the healthcare providers you have seen for your present pain. INCLUDE in TIME LINE

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

List all provider names, dates of care, and type of care on the Time Line (page # 5).

DENTAL HEALTH – PARAFUNCTION

Do you feel you clench (hold your teeth together)? ❑ Yes ❑ No	If yes, when?	❑ Day	❑ Night	
Do you grind your teeth at night?		❑ Yes	❑ No	
Do you feel that clenching or grinding your teeth contributes to your pain?		❑ Yes	❑ No	
Are any of your teeth worn, flattened, showing dentin, or have shiny areas?		❑ Yes	❑ No	
Has a dentist ever mentioned that you grind or clench your teeth?		❑ Yes	❑ No	
Do you have hard bony lumps, domes, bumps? ❑ roof of your mouth	❑ under your tongue		❑ No	
Do you have hot or cold sensitivity to your teeth - now or in the past? IF so_____		❑ Yes	❑ No	
Have your gums receded over the years around any teeth? ❑ Yes ❑ No	If so, where? _____			
Have you had your wisdom teeth removed? Yes, _____ yr remove	Upper Lower	Notes: _____	_____	
Have you ever broken, chipped, or cracked filling, crown, tooth, partial, implant?	Tooth #____	Year _____		
Dates of Orthodontic Treatment:	to	and	to	
Have you ever had failed: Implant	Root canal	Partial	Bridge	Veneer

ORAL APPLIANCE

If you have had more than one appliance, professional made or OTC, copy this form for each one.

Date Appliance Acquired: (Mo & Yr)_____ | Who Prescribed/**Provider:**_____

Mark ONLY ONE	❑ Nightguard (protect joint)	❑ Deprogrammer (NTI-anterior button)	❑ Repositioning (move jaw forward)	❑ Soft Biteguard (protects teeth)
❑ **Upper** ❑ **Lower**	❑ Store-Bought(OTC) ❑ Professionally Made	❑ **Hard** ❑ **Soft** ❑ **Hard outside, Soft inside**	❑ Full covers all teeth ❑ Partial-just posterior	❑ Partial–just anterior

List all appliances, details, dates received, and results of appliance use in the Time Line (page 5).

NUTRITION

Do you eat at least two balanced meals per day? ❑ Yes ❑ No		Are you on a soft diet? ❑ Yes ❑ No	
Do you take a daily multivitamin? ❑ Yes ❑ No		If yes, start date:	
Do you take any other supplements? ❑ Yes ❑ No		Do you have any food sensitivities? ❑ Yes ❑ No	
If yes, list: _____		If yes, list: _____	
Do you drink alcohol after 6 PM? ❑ Yes ❑ No		Do you drink caffeine after 4 PM? ❑ Yes ❑ No	

Indicate daily or weekly consumption of stimulants-depressants: Put in zero if no intake per week;

Stimulant Cups of Coffee	Glasses of Soda	Glasses of Tea
Depressant 12 ounce Beers	Glasses of Wine	Ounces of Liquor
Misc: Servings of Chocolate	Cigarettes	Energy drink, etc

Open Lock (Gets stuck wide open, unable to close)

1ST OPEN LOCKING: DATE: MONTH & YEAR? _____ NEVER HAD AN OPEN LOCK _____ (INITIAL IF TRUE)
DURATION OF 1ST OPEN LOCKING? _____ USED FORCE TO CLOSE? _____ OR GENTLE MANIPULATION? _____
PROGRESSION OF OPEN LOCKING: **FREQUENCY** #_____/WEEK OR MONTH OR YEAR (*PLEASE CIRCLE ONE*)
DURATION: _____MINUTES _____HOURS **DATE OF LAST OPEN LOCK**?_____

PATIENT SIGNATURE

I understand that honest answers to questions on this form are important to my health and 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 understand that if I have not answered all questions thoroughly, I may be asked about these at the exam, which may increase the cost of my exam.**

Patient's signature:	*Printed Patient Name:*	*Date:*