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 episodic 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 does pain last?___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.**

