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 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*) *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: How often pain occurs (1/day or 1/week) **Constant**: How often the pain flares (1/day or 1/week)

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 school days?	❑ Yes	❑ No	If work or do work at home-affect pain	❑ 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 been made due to pain/dysfunction?

What else do is noticed 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.**

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