Raleigh Facial Pain Center

JAW PAIN — TENSION HEADACHE — TOOTHACHE — EARACHE — RESTRICTED OPENING
PEDIATRIC TENSION HEADACHE — NERVE PAIN CHEW SYSTEM

Your pains is our primary concern

You have frequent or constant pain that is interfering with your quality life. You need someone who will listen to your symptoms and delivery diagnosis timely fashion. You need a health team that researches all data-history-symptoms for appropriate treatment plan. Many chronic pain patients try single acute pain treatments, but the relief is short lived or minimal. With chronic pain, it takes team to treat all the causes- improve health habits-manage world's stress & anxiety simultaneously to achieve success.

Why RFPC for your frequent jaw pain or malfunction jaw joint

Because your pain or inflammation comes from multiple sources, you need a team that understands the chew-ing system and how they integrate with other head and neck structures. You need team that understands chronic pain and mechanics of chewing system. Pain is destroying your quality life and you need a passionate coach to help you get back to pain free life. With over 30 years' experience treating and healing patients of all ages w/ chewing system malfunctions, we use our extensive knowledge and experience to seek and find the root causes of your pain. We use our empathy and loving care for patients to offer an integrated treatment plan to reduce your suffering.

Need to Understand Your Pain

We must get to know you and your pain. There is no information too small, too unimportant, too trivial about head & neck pain that we do not need to know about. We spend quality time listening and learning. We search for clues in all data patient provides as well as all-images-records dentist-family doctor apt-specialist-chiropractor-PT-massage-images-labs-etc. Your need for accurate diagnosis creates need to look under every rock and around every corner Our office provides: 1) Extensive pre-examination questionnaire. 2) Records request from all health care provider who provided any care your head or neck symptoms. 3) Our team will assist you in all phases of collecting accurate data. 3) Understanding your pain thru detailed examination.

Your need for accurate diagnosis

Please do not underestimate the need for information requested. It does not matter if you think it is connected to your problem. If you have ever had problem-pain-issue with any component of pain or dysfunction, please help us help you by giving all detail you can give. We must have the detailed pre-examination questionnaire a minimum of 3-5 days before your scheduled appointment; we will provide and exact date and time for you to avoid confusion.

What is chronic pain

Chronic pain is a moderate to severe pain that defies single treatments. Chronic pain develops from slow deterioration of our health habits w/ prolong period stress/anxiety followed by trauma-injury-long open mouth procedure-increase clenching/grinding sets you up for ongoing pain. Formula=trauma + anxiety + Health habits + pains

Importance Previous Records

To assist you at remembering all the details of any past care, please contact previous health care providers to provide relevant medical-dental-ENT-Neurology-Chiropractor-Orthopedic-PT-psychology records – *no matter how old.*

Detailed Exam

Please arrive 15 minutes before your exam time. You will spend 1.5 hours quality time with the doctor is based on the amount time you have reserved with the doctor. Prior to leaving, you will schedule your treatment planning & team selection appointment, in one week. We recommend you invited spouse-parent-significant other-partner to assist you with our findings, diagnoses, and treatment plan.

Cost Examination

The cost review records & examination $425 for your detail examination. We accept many forms of payment (Visa, MasterCard, Amex, Discover, HSA cards, checks, cash, & CareCredit). You may file for reimbursement from your insurance provider by using the completed forms we provide (CMS 1500). We may assist with any insurance denial.

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1) Diagnose is possible only with your detail information
2) Completely fill out pre-examination questionnaire
3) Do not leave any section blank
4) Do not skip neck, even discomfort-tight stiff-sore are reported
5) Different headache locations on separate forms
6) Each MVA, FALL, or Traumas on separate form
7) Time line or evolution of your pains, development of your pain
8) You can request records-images from previous doctors, dentist, specialist
9) Sign patient consent form (required to request records)
10) Return pre-exam questionnaire as soon as possible
11) Call us or we will call you to schedule
12) Mark your calendar w/date of examination
13) Arrive 15 minutes early for your appointment
14) Bring: a) insurance card, b) method of payment, c) all appliances
13) Anticipate 1.5 hour for the examination
14) Research "your" pain on website (www.raleighfacialpain.com) or any info
15) "Your" reservation can be changed 5 working days in advance
16) We accept credit cards, debit cards, checks, cash, Care Credit
17) Letter of medical necessity is provided at treatment planning in 1 week

Signature of Patient/Parent/Guardian

Printed Name of Patient

Date

FOR OFFICE USE ONLY

Office Use: Accepted by

Date

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Diplomate, American Board of Orofacial Pain

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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: Last 4 digits:		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:		

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION — PLEASE PRINT LEGIBLY

Patient Full Name:	Date of Birth:	SSN (Last 4 Numbers Only):
Home Address:	City/State:	ZIP Code:
Please fill out this page, except for the box below.	Copy page, add medical or dental doctor	

Request Release of Records From: **PRACTICE-SPECIALTY:** _____

Name_____ Phone_____

Address_____
Street City State Zip

How would I like the records to be released? Please expedite records transfer-due pain needs!

❑ Paper Copy ❑ Mailed to Requestor ❑ Emailed to Requestor: phyllis@raleighfacialpain.com

❑ Picked up by _____ ❑ UPS-Fed Ex _____

❑ Faxed to Requestor: Keith A. Yount, DDS, PA / Raleigh Facial Pain Center 919-781-6430 (FAX #)

Purpose: ❑ Diagnostic Information ❑ Insurance ❑ Legal ❑ Personal ❑ Other _____

Treatment Date(s): ❑ Treatment dates from _____ to _____ (please be specific) OR ❑ ALL treatment dates

Information to be Released:

❑ Entire Health Record (including clinical notes) ❑ Imaging (specifically Panorex, CT, CBCT, MRI)

I Understand That:

- Without my written revocation, this Authorization will automatically expire one year from the date signed below, unless I request an expiration date less than one year.
- I may ***revoke*** this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation.
- **The information to be released may include a diagnosis or reference to the following conditions: acquired immune deficiency syndrome (AIDS), genetic testing, human immunodeficiency virus (HIV), or sickle cell anemia**.
- Information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Signature: My signature is required to validate this Authorization. If I do not sign this authorization, Keith A. Yount, DDS, PA/Raleigh Facial Pain Center, will still provide orofacial pain care. I understand that Raleigh Facial Pain Center may charge for copies of medical records, according to North Carolina General Statutes. **This authorization will expire on _____ or one year from date of this form.**

_____ _____ _____
Signature of Patient/Guardian/Personal Representative Date Relationship (parent, guardian, etc)

_____
Witness

Visit us on the web at www.raleighfacialpain.com

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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 / 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
	❑ 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:

Name:	Relationship:
Name:	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:

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PRIMARY CONDITION

Complete a copy of this page for each location of discomfort, pain, dysfunction, or concern.
Describe ONE and ONLY ONE body part per page.

Define location (Write ***ONE & 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 time: (Date) _____ | Describe below 1st pain onset (circumstance, event, time day, level pain):

Notes:

Trauma: (*list years occurred*) | Trauma: | 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 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 JAW 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 go 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	Are any of your joints double jointed ?	❑ Yes ❑ No
Does condition interrupt sleep?	❑ Yes ❑ No	Ever have IBS, reflux, GERD symptom?	❑ 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.**

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NECK INFORMATION

If you have or ever had neck discomfort (tight-stiff-sore) in neck area. If you have ever sought treatment for neck discomfort – no matter how minor or how far in the past.

I have never had any neck discomfort, pain, trauma of any type. _____ *(initial if true for you)*

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

First Noticed Discomfort: _____ | Describe 1st neck discomfort _____

Detail:

Trauma: (*list years*)	Auto accidents-MVA:	Falls:	Blows to neck:
Initial if no MVA-Falls(___)	_____	_____	_____

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*) ❑ Tight ❑ Stiff ❑ Sore ❑ Superficial ❑ Deep ❑ Aching
❑ Shooting ❑ Sharp ❑ 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 became constant, when DATE _____

Worse on workdays? ❑ Yes ❑ No | Has the pain inc freq, dura, intensity? DATE _____

Does condition interrupt sleep? ❑ Yes ❑ No | Have you seen providers for neck? ❑ Yes ❑ No

What increases the problem? (*check **all** that apply*) ❑ Head tilt ❑ Rotation ❑ Look up ❑ Look down
❑ Physical activity ❑ Clenching ❑ Touching face ❑ Opening wide ❑ Certain foods ❑ Weather ❑ Stress
❑ Emotional upset ❑ Cold ❑ 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*)

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.**

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WHO HAVE YOU SEEN IN LAST 20 YEARS & WHY ?

We need to understand your pain or joint malfunction journey. ***The main objective is to record the order* of all *events.*** *Tell when any of your symptoms occurred, when did jaw, neck or head pain start.* When did each symptom or area of symptom change? 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 to Use as an additional page.

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	Locked jaw upon awakening	Right side stuck, pain and loud pop when forced
March 2008	Restricted opening every 2-3 weeks	Dentist Dr. Brady referred to Dr Yount
Month-Year	**Description of event**	**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 **neck-jaw-headache**?	❑ Yes	❑ No

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HEADACHE (HA) (COPY FOR MIGRAINE HEADACHE)

SEPARATE HEADACHES BY LOCATION, No matter how minor, infrequent, or in the past.
ONE & ONLY ONE headache per page _____ **(initial if NO Headache, ever)**

How often is this headache?	Frequency: (number) ___per day ___per week ___per month
***ONLY ONE* LOCATION**:	❑ Side of head ❑ Back of head ❑ Behind eyes ❑ Whole head

Date **1st HA** -_____ **Dates Treatment?**_____ **SIDE: Right**:___ **Left** ___ **Both**___

Is warning before headache? YES NO DATA

Is headache associated with any event, condition, or circumstance? ❑ No ❑ Yes

Duration of headache: (*enter number to right*): _____ seconds _____ minutes _____ hours _____ days

Worst pain: (*circle #*): 0 1 2 3 4 5 6 7 8 9 10 most pain ever

Least pain: (*circle #*): 0 1 2 3 4 5 6 7 8 9 10 most pain ever

Adjectives: dull ache sharp shooting throbbing pounding | Tingling crawling deep superficial

Onset/Pattern: gradual abrupt | off & on continuous

Since onset pain: ❑ Same ❑ Better ❑ Worse HA changed:___ _____

Worst time day: (*check*) ❑ Awakening ❑ AM ❑ Afternoon ❑ Evening ❑ night ❑ Sleeping Other:

Worse on workdays? ❑ Yes ❑ No | Affected weather? ❑Yes ❑ No

Interrupt sleep? ❑ Yes ❑ No | Family members with headaches? ❑ Yes ❑ No

Makes HA worse?

Makes headache better?

Daily, weekly, or monthly pattern of headache?

Describe light or sound sensitivity after onset headache?

If Headache is constant, date became constant: _____, explain: _____

List all medications ever taken for this headache _____

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?

Year the noise START. PROGRESS NOW | Did sound change? Click to pop to gravel

No TMJ Noise	**Initial Onset**			**Progression-Change**			**Current Noise**		
____ (initial)	**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 TMJ's	❑ Pop	❑ Click	❑	❑ Pop	❑ Click	❑ Yes	❑ gravel	❑ Click	❑ Yes
How often occurs (Frequency)	❑ Intermittent ❑ On all open	❑ frequent		❑ Intermittent ❑ on all open	❑ most of time		❑Intermittent ❑ on all open	❑ ALL	
It can be heard (Loudness)	❑ Only by me ❑ Across room	❑ Others nearby		❑ Only by me ❑ Across room	❑ Others nearby		❑ Only by me ❑ Across room	❑ Others nearby	

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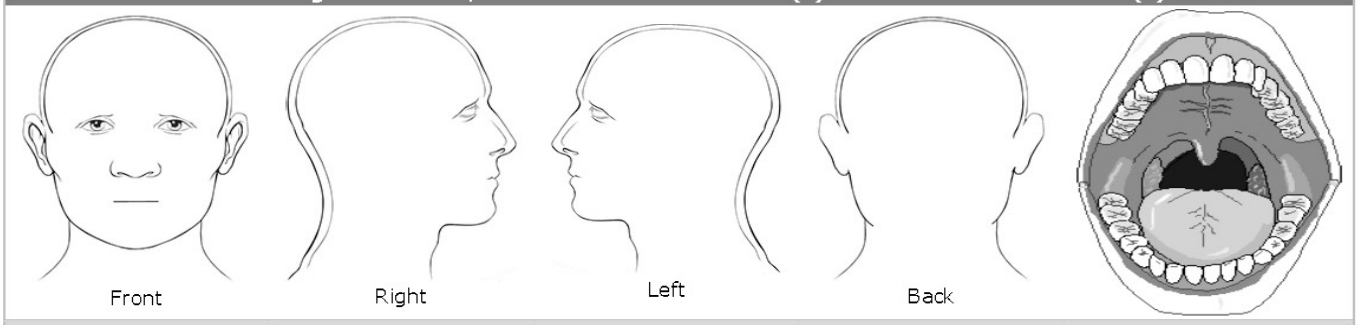
PAIN-DISCOMFORT: LOCATION FOR HEAD, NECK, JAW, TOOTH

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



DOES JAW EVER LOCK, GET STUCK, CAN'T OPEN ALL THE WAY?

Normal Opening	❑ 3 fingers	❑ 3.5 fingers	❑ 4 fingers	❑ Never Had Restricted Opening	
1st Restricted Opening	❑ 1 finger	❑ 1.5 fingers	❑ 2 fingers	**When did locking start ?** _____	
Which side feels restricted?	❑ Right	❑ Left	Feels like:	❑ Over stretched Hurt open	❑ Stuck- Block
How jaw **Often**	Jaw Lock	Duration___	____ pain	**If stayed locked, when start ?**_____	
Manipulate Force open	Massage	_____	(Circle one)	**Describe event of 1st RO**_____	

SYMPTHETIC SYSTEM UP-REGULATION

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 or type, tx, counseling, meds, 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?

Frustrations, concerns, or problems w/ chronic pain, chronic pain therapy, or any aspect pain journey?

What percentage of relief would be acceptable from treatment? %

What do you expect by from Raleigh Facial Pain Center team?

EXERCISE OR CARDIOVASCULAR THERAPY

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

Type exercise: walk run tread swim bike	Time spent:	Distance:
Weight: lbs.	Height: ft. in.	Waist: in. # years:

COMPUTER ERGONOMICS CIRCLE ONE: tablets laptops Desk top Phone

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

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SLEEP HISTORY -- COPY FOR DIFFERENT PERIODS 1) SLEEP MEDS OR 2) NO 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 disrupted?	
How many hours are you in bed?		How many hours are you asleep?	
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

List all medications ever taken to improve sleep & dates?

Sleep study: please enter year_____; Doctor _____ Prescribed: CPAP, Sleep appliance, surgery_____

Check all that apply: ❑ Breath Holding ❑ 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

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

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

Notes: 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(_____) **Father (_____)**
Mother's Mother (_____) **Father's Mother (_____)**
Mother's Father (_____) **Father's Father (_____)**

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

Name	Dose	Time Taken	Reason	Prescriber

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CONDITION DESCRIPTORS

Some of the words below may describe your condition. ***Circle one word from each section 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 NECK JAW HEAD PAIN

Please circle any medications you have taken for the problems for which we are seeing you.

Abilify	Bupropion	Decadron	Flexeril	Lorazepam	Oxy IR	Restoril	Trazodone
Acetaminophen	Buspirone	Demerol	Flonase	Lorcet	Oxcarbazepine	Risperidone	Trileptal
Acyclovir	BuSpar	Depakote	Fluoxetine	Lortab	Oxycodone	Rizatriptan	Trintellix
Advil	Butazolidin	Desyrel	Fosamax	Lunesta	Oxycontin	Robaxin	Tylenol
Aimovig	Botulinum	Desipramine	Frova	Lyrica	Pamelor	Rofecoxib	Trazodone
Aleve	Cafergot	DHE 45	Frovatriptan	Maxalt	Parafon Forte	Sansert	Ubrelvy
Alprazolam	Calan	Diazepam	Gabapentin	Meclizine	Parnate	Savella	Ultracet
Ambien	Cambia	Diclofenac	Geodon	Meloxicam	Paroxetine	Serax	Ultram
Amerge	Carbamazepine	Dilantin	Gralise	Meperidine	Paxil	Sertraline	Viibryd
Amgen	Carisoprodol	Diphenhydramine	Halcion	Meprobamate	Pentazocine	Seroquel	Valium
Amitriptyline	Celebrex	Dolobid	Haldol	Methocarbamol	Percocet	Serzone	Valdecoxib
Anacin	Celexa	Doxepin	Humira	Methotrexate	Percodan	Sinequan	Valproic acid
Anaprox	Chlorpromazine	Drixoral	Hydrocodone	Mycostatin	Percogesic	Skelaxin	Venlafaxine
Antibiotics	Clonazepam	Duloxetine	Ibuprofen	Midrin	Periactin	Soma	Verapamil
Aredia	Codeine	Duradrin	Imipramine	Mobic	Phenaphen	Sonata	Vicoprofen
Arthrotec	Compazine	Effexor	Imitrex	Nabumetone	Phenytoin	Sumatriptan	Vicodin
Aspirin	Cortisone	Elavil	Inderal	Naprosyn	Prednisone	Tavist	Vioxx
Ativan	Citalopram	Empirin	Indocin	Nardil	Pregabalin	Tegretol	Voltaren
Axert	Cyclobenzaprine	Equagesic	Indomethacin	Naratriptan	Propoxyphene	Temazepam	Wellbutrin
Baclofen	Cyclospasmol	Eszopiclone	Ketaprofen	Nasacort	Propranolol	Tizanidine	Xanax
Beconase	Cyproheptadine	Escitalopram	Klonopin	Nefazodone	Lorazepam	Tofranil	Zanaflex
Belsomra	Cymbalta	Excedrin	Lamictal	Neurontin	Provigil	Topiramate	Zaleplon
Benadryl	Dalmane	Emgality	Lexapro	Norflex	Prozac	Topamax	Zoloft
Bextra	Darvocet	Fioricet	Lioresal	Norgesic	Relafen	Toradol	Zolpidem
Boniva	Darvon	Fiorinal	Lithium	Norpramin	Remeron	Tramadol	Zolmitriptan
Bufferin	Daypro	Fluconazole	Lodine	Oxaprozin	Requip	Tranxene	Zyprexa

LIST MED & DESCRIBE <u>UNUSUAL REACTIONS</u> TO ANY MEDICTIONS

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GENERAL MEDICAL HISTORY

Circle pathology & indicate year of onset. Give details in space provided below.

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	Hernia: Hiatal __ Abdominal__ Inguinal__	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: Constipation __ Diarrhea__ IBS___	High Blood Pressure	Stomach/Digestive Problems
Cardiac Conditions: MVP___/ Murmur____	Hypermobility: wrist finger knee elbow	Stroke
Circulatory Problems	Joint Noises	Thyroid Problems (hyper, hypo, tumor)
Cirrhosis of Liver	Kidney Conditions	Tonsillitis
Congestive Heart Failure	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)_____

4) _____

List hospitalizations or surgeries (*of any type*)

Date	Reason	Treatment

GI symptoms: CIRCLE: IBS GERD ACID REFLUX ULCERATIVE COLITIS CROHN'S

1st year gut (GI) symptoms appeared _____ 1st year treated _____ Medications used: _____

Treatments _____ GI Surgery (year): Lap Band, Gastric Bypass _____

HEALTHCARE PROVIDER SEEN FOR JAW, HEAD, NECK PAIN

Please circle the healthcare providers you have seen for your pains.

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

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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? Where?_____	❑ Yes	❑ No
Have you had your wisdom teeth removed? Yes, ____ yr remove Upper Lower Notes:	_____	_____
Have you ever broken, chipped, or cracked a filling, crown, tooth, partial, implant, etc: Tooth____ Year_____ Tooth____ Year_____ Tooth____ Year_____ Tooth____ Year_____		
Dates of Orthodontic Treatment: 1) from to : 2) to		
Ever broke-crack-chip-fail: (yr):Implant Root canal Partial Bridge Veneer		

ORAL APPLIANCE

More than **One appliance, copy this section for each one**

Date Appliance Acquired: (Month/Year) _____ Who Prescribed/**Provider:** _____

Mark ONLY ONE ❑ Nightguard (hard full coverage) ❑ NTI (anterior deprogram) ❑ Repositioning (move jaw forward) ❑ Soft Biteguard (protect teeth)

❑ **Upper**	❑ Over Counter	❑ **Hard** ❑ **Soft**	❑ Full covers all teeth
❑ **Lower**	❑ Professionally Made	❑ **Hard outside, Soft inside**	❑ Back teeth ❑ Front teeth

Successful

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 (Stuck wide open & unable to close)

1st open locking occurred? month & year_____ **Jaw Stuck Open: right left both**
Duration of 1st open locking? _____ **Details: _____**
Gentle manipulation or forced closed _____ **Any Tx for open lock _____**
Episodes open locking? frequency____, duration_____ **NOTES on back: _____**

Please help keep down cost of the exam. I have answered all questions to the **best of my ability**. I verify that **all** information about my health has been provided, including all tests, images, examinations, medications, outcomes, home remedies, and especially traumas-falls-blows. I verify the completeness of this form with my signature. **If you have not answered all questions w/ detail, you risk impairing diagnosis and treatment plan success.**

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