

Health Questionnaire for Head, Face, and Neck Pain evaluation

First Name

Middle Initial

Last Name

What shall we call you?

Your Date of Birth

Gender Female Male

Street Address

City State ZIP

Home Phone

Work phone

Cell Phone

Which phone do you prefer we contact you on? Home Work Cell

Email address *

How would you like appointment reminders sent ? Email Phone Text message

Marital Status Single Married Partner for insurance Separated Divorced Widowed

Spouse / Partner full name

Whom shall we contact in a medical emergency?

Emergency contact phone

Your Employer

Job description

How were you referred?

Acquaintance Name

Doctor Name

Internet Newspaper Yellow pages

Your Chief Complaint

Describe the problem that you are most concerned about.

How long have you had this problem?

What do you think may have caused this problem?

Describe how this problem gets worse or better during the day.

What result would you like as from treatment here?

Pain history

Please check all head pain you have.

No head pain

Frequent headaches

Migraine headaches

Pain in front of head

Pain in entire head

Pain on top of head

Pain in the back of head

Pain in the temples

Pain or pressure behind the eyes

Please mark all ear symptoms you have.

No ear symptoms

Pain in ears

Pressure in ears

Buzzing in ears

Ringing in ears

Pain behind ears

Pain in front of ears

Dizziness

Please mark all neck symptoms you have.

No neck symptoms

Throat pain

Feeling that an object is stuck in the throat

Chronic sore throat

Swelling in neck

Neck pain

Limited movement of neck

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Please mark all shoulder, back and arm symptoms you have.

- | | |
|--------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> No shoulder, back, or arm symptoms. | <input type="checkbox"/> Middle back pain |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Hand pain | <input type="checkbox"/> Numbness or tingling in the arms |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Numbness or tingling in hands |

Please mark all mouth symptoms you have.

- | | |
|--------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> No mouth symptoms | <input type="checkbox"/> Missing teeth |
| <input type="checkbox"/> Tooth pain | <input type="checkbox"/> Burning tongue |
| <input type="checkbox"/> Gum pain | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Broken teeth | <input type="checkbox"/> Painful sore in the mouth |

Please mark all nasal or sinus symptoms you have.

- | | |
|-----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> No nasal or sinus symptoms | <input type="checkbox"/> Sinus pain |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Clogged nasal passages |
| <input type="checkbox"/> Chronic sinusitis | |

Medical History

Your primary care provider, with contact information:

Are you currently seeing physicians or alternative providers for treatment? Yes No

If yes, list all providers and reasons for treatment.

Are you taking any medications, including over-the-counter and nutritional supplements? Yes No

If yes, list the medications.

Have you ever had a reaction or side effect to the following?

- | | |
|-------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> Metal |
| <input type="checkbox"/> Food | <input type="checkbox"/> Other |
| <input type="checkbox"/> Latex rubber | <input type="checkbox"/> No adverse reactions |
| <input type="checkbox"/> Medications | |

Female:

Are you pregnant? Yes No Your due date

Have you gone through menopause? Yes No

Do you have or have you had any of the following?

- | | | |
|--------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> No diseases or disorders | <input type="checkbox"/> Multiple chemical sensitivities | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Snoring, even a little | <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Daytime sleepiness | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Multiple nighttime awakenings | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Gastric reflux | <input type="checkbox"/> Seizure disorders | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Tooth grinding while sleeping | <input type="checkbox"/> Cancer | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Leukemia | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Radiation therapy | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Vascular disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bisphosphonate therapy (Fosamax, Boniva, etc.) | |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Joint replacement | |

Any other disease or disorder What:

Your general dentist, with contact information.

Would you like us to send you a monthly health newsletter by e-mail? Yes No

Today's date:

Please type or write your name to confirm your signature:

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