INTRODUCTION to CHRONIC PAIN
OR
DYSFUNCTION of the CHEWING SYSTEM

Welcome
We appreciate the opportunity to get to know you, your child and your child's pain. The team at Raleigh Facial Pain Center is dedicated to helping your child 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 child's pain. We then use an integrated multidisciplinary treatment approach to decrease your child's suffering. We utilize the latest scientific advances combined with highly trained healthcare professionals who share knowledge, skill, and empathy with you and your child.

Need to Understand Your Pain (Pre-exam questionnaire)
We begin our evaluation process by getting to know your child and the pain or dysfunction they 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 child's pain by the pain interview at the examination. Filling out the detailed questionnaire is a tedious process but one that is vital to helping us determine your child's pathology (pain or abnormal function). The better you communicate your child's 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 Your Child (Pre-exam questionnaire)
You may think the need to know the patient behind the pain is just a catchy idea. If you understood 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 child's exam and to accurately diagnose their conditions, we need all the data related to each and every pain or dysfunction (can't open mouth wide) in the head and neck region.

Previous Records (Pre-exam questionnaire)
To assist you at remembering all the details of any past care, please contact previous health care providers to provide relevant medical and/or dental records – no matter how old. This may include exam information, doctor's 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 health care cost down by arriving 15 minutes before your child's 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, and your child, 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, prepare a management and treatment plan especially for your child. Prior to leaving the initial exam, you will schedule the second visit (consult) in approximately one week, where we review your child's 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 child's improved lifestyle.

Important Significant Other: It is important that anyone you deem as important and involved with your child's care (spouse, sister, friend) attend the consult. The person that makes the financial and healthcare decisions in the family needs to attend the second appointment to understand what is involved to help your child with pain reduction and/or to improve their jaw joint health and 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 the 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 extra time needed to extract the information chairside. We accept many forms of payment (Visa, MasterCard, Discover, HSA 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 understanding of your child's conditions and management protocol. Each patient is unique and has specific needs, the consultation is to outline specific needs that need to be addressed to successfully manage the pain and equip you and your child 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:

1) **Completely** fill out pre-examination questionnaire (do not leave any section blank)
2) Separate different headaches to separate forms
3) Detail all accidents and traumas on separate forms provided
4) Time line or evolution of pain needs all important details and events
5) Obtain any records from previous doctors or dentist that may help in exam & diagnosis
6) Sign the patient consent form (so that we may converse with your doctors)
7) Return pre-exam questionnaire by designated time on designated date
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 one hour for the doctor to get to know you and your pain in examination
12) Reading "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 working days in advance
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)

Patient's Name: _____

_____ _____ _____
Signature of Parent/Legal Guardian Printed Name of Parent/Legal Guardian Date

Office Use: Accepted by _____ Date _____

Raleigh Facial Pain Center

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

4201 Lake Boone Trail, Suite 107
Raleigh, NC 27607
Phone: 919-781-6600
Fax: 919-781-6430

NEW PEDIATRIC PATIENT INFORMATION

PLEASE PRINT LEGIBLY

Child's Full Name:	❑ Male	❑ Female
Name by which we should address your child:	Date of Birth:	Age:
Address where child lives:	City/State:	ZIP Code:
Social Security Number:	Grade and School:	
Other Children in Family? Names and Ages:		

RESPONSIBLE ADULTS' INFORMATION

Person responsible for account:			
Social Security Number:	Drivers License Number/State:		
Home Address:	City/State:	ZIP Code:	
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	Email:
Employer:	Job Title:	Length of Employment:	
Work Address:	City/State:	ZIP Code:	
Spouse Name:	Cell Phone: ( )	Work Phone: ( )	
Employer:	Job Title:	Length of Employment:	
Work Address:	City/State:	ZIP Code:	

Emergency Contact: (***Required***)	Relationship	Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
In addition to the people named above, who else may bring the child to the office? (*name & relationship*)				

HEALTHCARE PROVIDERS INFORMATION

Who may we thank for referring you?	
Pediatrician/ Medical Doctor:	Phone: ( )
Office Address:	
Date of Last Physical:	Frequency of physicals:
Findings:	
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 to child:
Social Security Number:	Date of Birth:

Address, if not same as child:

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 this child's care. I authorize release of information to Raleigh Facial Pain Center from other healthcare providers involved in my child's medical care.

I understand that it is my responsibility as a parent or guardian for this child to keep medical information up-to-date and to advise this practice of any changes in health, medications, or other healthcare issues. I agree to abide by all state and federal guidelines if my child receives medications or obtain a certificate of disability. I understand that it is my responsibility to obtain insurance pre-authorization if it is necessary. I understand that neither Medicare nor Medicaid (including North Carolina Health Choice) will reimburse for services provided by Raleigh Facial Pain Center and I waive my right to seek reimbursement under these programs. By seeking care for my child, I assume financial responsibility for all charges and agree to pay the child's account in full at the time services are rendered.

Signature:	*Printed 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 child's healthcare:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Signature:	*Printed Name:*	*Date:*

Office Use Only

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

❑ Refused to sign ❑ Communication barriers prevented obtaining acknowledgement ❑ An emergency situation prohibited obtaining acknowledgement ❑ Other:

OVERVIEW

Briefly report your child's primary concern: jaw-face-head-ear-tooth pain or can't open wide. Use the **exact words** your child uses to describe the pain. Use their locational words and adjectives to describe the problem)

_____**(do not leave blank)**

HEALTHCARE PROVIDER HISTORY

Please circle the healthcare providers seen or consulted for the present condition.

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 6).

DENTAL HEALTH - PARAFUNCTION

Does the child clench (hold the teeth together)? ❑ Yes ❑ No	If yes, when? ❑ Day	❑ Night
Does the child grind his/her teeth at night?	❑ Yes	❑ No
Do you feel that clenching the teeth? DAY _____ NIGHT_____	❑ Yes	❑ No
Are any of your child's teeth worn areas teeth (flattened or shiny areas)? Ant _____ Post _____	❑ Yes	❑ No
Has a dentist ever mentioned that your child grinds their teeth? Y N or clenches? Y N	❑ Yes	❑ No
Does the child have hard bony lumps? ❑ in the roof of their mouth ❑ under their tongue		❑ No
Has the child ever sucked their thumb? For how long _____ years?	❑ Yes	❑ No
Have baby teeth been removed? _____ Any permanent teeth been removed? _____	❑ Yes	❑ No
Has the child ever broken, chipped, or cracked a filling, crown, or tooth?	❑ Yes	❑ No
Dates of Orthodontic Treatment: to WHY?_____ Retainers? _____	❑ Yes	❑ No
Has your child ever been put to sleep for surgery?	❑ Yes	❑ No
Has your child ever chewed gum on a daily basis? _____ # sticks or pieces per day	❑ Yes	❑ No
Has your child ever had trauma to mouth-face-jaw-neck? Date _____ Describe _____	❑ Yes	❑ No

ORAL APPLIANCE

If your child has any oral appliance, including retainers, please bring them to the exam.

Date Current Appliance Acquired:_____ Who Prescribed/Provided:_____

Mark all that apply: ❑ Splint (hard-cover all teeth) ❑ Deprogrammer (NTI-anterior button) ❑ Repositioning (move jaw forward) ❑ Soft Nightguard (bruxing, grinding)

❑ Upper	❑ Store Bought	❑ Hard	❑ Soft	❑ Full covers all teeth	
❑ Lower	❑ Professionally Made	❑ Hard outside, Soft inside		❑ Partial-just posterior	❑ Partial–just anterior

EXERCISE or CARDIOVASCULAR CONDITIONING

Average weekly number of days your child exercises? 0 1 2 3 4 5 6 7

Type of exercise:	Time spent:	How long exercise at this level:

Weight: lbs.	Height: ft. in.	Waist: in.	Play sports?:_____

COMPUTER POSTURE (if use more 1 device fill out 1 for each)

Fill out table	Desk	Tablet	CELL-Phone	Especially#__ Hours on Each device	
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:	

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.**

NECK PAIN DETAILS

Provide requested information if child has or ever had neck pain or if has ever sought treatment for neck pain – no matter how minor or how far in the past.

My child has never had any neck pain or trauma of any type. _____ (initial if this is true)

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: **Episodic pain:** *some periods are pain-free* **Constant pain:** *continuous with flares of increased 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 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 schooldays?	❑ Yes ❑ No	Affected by weather?	❑ 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.**

CONDITION TIME LINE

We need to understand your child's joint noise, jaw discomfort, or restricted opening journey. ***The main objective is to record the order of events.*** We want even the littlest detail, any suspicion of cause, or even what you may feel is unimportant. Recording when all your symptoms developed or occurred, what has been done or treated or managed the pain or dysfunction, and the results of any care on each particular pain. This medical time line should include every clinician consulted, all diagnostic tests, every related event, all traumas, and all therapies with results. You will reduce the time spent collecting data in the office which saves you money. Do your best to provide all details. **Use an additional page if necessary.**

Approximate Date	Event	Notes
2000-02	Ortho treatment followed by retainers	Dr Barney Rubble, cross bite, 2 upper molars extracted
2003	All 4 wisdom teeth extracted	Dr Wiley Coyote oral surgeon
2005	Right jaw started popping	No pain, noted with gum chewing
01/07/2007	Knee surgery, locked jaw upon awakening	Right side stuck, pain and loud pop when forced
since June 2008	Restricted opening every 2-3 weeks	Dentist Greg Brady referred to Dr Yount
May 2012	Headaches every morning, jaw pain	Ibuprofen, heat packs
April 2013	Constant jaw & ear pain, headache a lot	ENT Dr Ben Walton, no infection, refer Dr Yount
Approximate Date	**Event**	**Notes**

Did you list all changes 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? Did it help or not?	❑ Yes	❑ No

HEADACHE HISTORY

Report all headaches, no matter how infrequent or low level pain. Separate migraines from side head, frontal-sinus, and behind eye headaches . Describe ONE and ONLY ONE headache per page.

Child ever have headaches? ❑ 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	
When did you start having headaches? Date:	Age:
Do you have any warning before headaches start? ❑ 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 a number*) 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 headaches worse?	
What makes headaches better?	
What is headache's daily, weekly, or monthly pattern?	
Describe light, balance, or sound sensitivity with the headaches.	
List all medications taken for headache (current or historical):	

TEMPOROMANDIBULAR JOINT NOISE

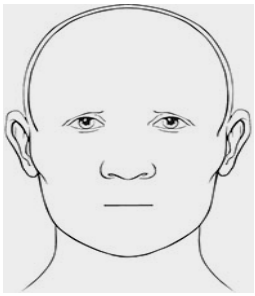
Describe when the noise began, how & when it has changed, and present observations.

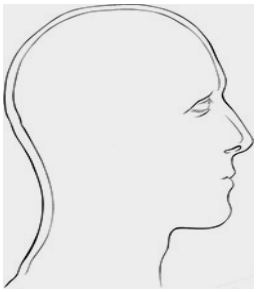
Did noise ever stop for a period? ❑ Yes ❑ No	Did noise get louder or more frequent? ❑ Yes ❑ No
Did it start on one side then move to or add the other side? ❑ Yes ❑ No	Did sound change? For example, click to pop or gravelly sound. ❑ Yes ❑ No

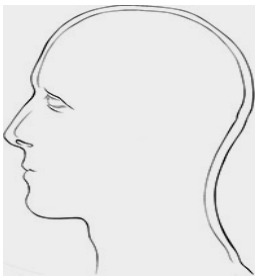
No TMJ Noise	**Initial NOISE**			**Noise Change over time**			**Current NOISE**		
Initial_____	**Month & Year: _____/_____**			**Month & Year: _____/_____**			**Month & Year: _____/_____**		
	Sound		**Pain?**	**Sound**		**Pain?**	**Sound**		**Pain?**
Right Only	❑ Pop	❑ Click	❑ Yes	❑ Pop	❑ Click	❑ Yes	❑ Pop	❑ Click	❑ Yes
Left Only	❑ Pop	❑ Click	❑ Yes	❑ Pop	❑ Click	❑ Yes	❑ Pop	❑ Click	❑ Yes
Both Sides	❑ Pop	❑ Click	❑ Yes	❑ Pop	❑ Click	❑ Yes	❑ Pop	❑ Click	❑ Yes
How often it occurs?	❑ Occasional ❑ Intermittent	❑ 1/3 open ❑ ½ open		❑ Occasional ❑ Intermittent	❑ on all opening		❑ Occasional ❑ Intermittent	❑ on all open	
It can be heard	❑ Only by me ❑ Across room	❑ Others nearby		❑ Only by me ❑ Across room	❑ Others nearby		❑ Only by me ❑ Across room	❑ Others nearby	
When does noise occur?	❑ Early opening ❑ Late opening	❑ Mid-opening ❑ Open & close		❑ Early opening ❑ Late opening	❑ Mid-opening ❑ Open & close		❑ Early opening ❑ Late opening	❑ Mid-opening ❑ Open & close	

PAIN LOCATION

On the diagrams below, outline the painful areas (jaw, neck, head) and shade in those area(s). Be specific!


Front


Right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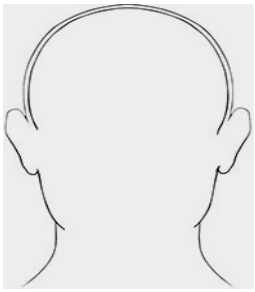
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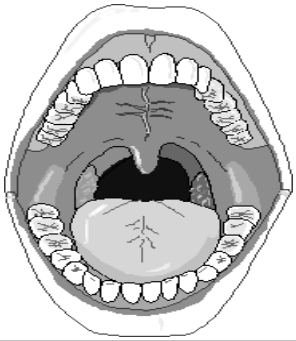

RESTRICTION IN OPENING

Normal Opening	❑ 3 fingers	❑ 3.5 fingers	❑ 4 fingers	❑ Never had Restricted Opening **Initials** _____
Restricted Opening	❑ 1 fingers	❑ 1.5 fingers	❑ 2 fingers	**1st Restrict Opening: date**_____
Which side feels restricted?	❑ Right	❑ Left	Feels like:	❑ Tight rubber band ❑ Stuck door
Episodes # _____per	❑ Day	❑ Week	❑ Month	**Constant restriction (Date):**

CENTRAL NERVOUS SYSTEM

Which word does the child use to describe himself/herself? ❑ Calm ❑ Tense

Has the child experienced: Stress ❑ Yes ❑ No Anxiety ❑ Yes ❑ No Depression ❑ Yes ❑ No

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

Has child ever been under care for depression, anxiety, or high stress? ❑ Yes ❑ No

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

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

Briefly explain any "yes" answers:

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

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

What are your frustrations, concerns, and problems with jaw-neck-head pain, TMJ therapy, or any aspect of their pain journey up to the present?

What percentage of relief would be acceptable from treatment? %

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

NUTRITION

Does child eat at least two balanced meals per day?	❑ Yes	❑ No	Has current condition changed your child's eating habits?	❑ Yes	❑ No
Multivitamin or supplements?	❑ Yes	❑ No	If yes, how:		
If yes, list:_____	_____	_____	Does child have food sensitivities?	❑ Yes	❑ No
Does child drink caffeine after 6 PM?	❑ Yes	❑ No	If yes, list:		

Indicate daily consumption of the following:

Cups of Coffee	Glasses of Soda or Tea	Servings of Energy drinks:

SLEEP

Rate the child's overall sleep quality:	poor	0	1	2	3	4	5	6	7	8	9	10	great

What time does the child normally go to bed?	Bedtime varies by (*number*)	minutes	hours
Is the child refreshed after sleeping? ❑ Yes ❑ No	How long has the child's sleep been unrefreshed?		
How many hours does he/she devote to sleep?	How many hours does the child actually sleep?		
Trouble falling asleep? ❑ Yes ❑ No	How long to fall asleep?	minutes	hours
Trouble maintaining sleep? ❑ Yes ❑ No	Number of awakenings per night:		
Does the child awaken due to pain? ❑ Yes ❑ No	How long to resume sleep?	minutes	hours

What medications has the child taken (now/or in the past) to improve sleep?

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

LIFE EVENTS

Child lives with: Married Parents Single Mom Single Dad Parent & Step-Parent

Guardian Grandparents Other: Details: _____ _____

Describe family's adult relationship: ❑ Excellent ❑ Satisfactory ❑ Unsatisfactory ❑ Very unsatisfactory

Describe your family environment: ❑ Happy ❑ Bland ❑ Stressed ❑ Hostile

Do you consider your family a religious family? ❑ Yes ❑ No

Experienced any of the following? When?	**Date**		**Date**
❑ serious illness of friend or loved one		❑ bitter divorce	
❑ yelling/threatening environment		❑ fragmented family	
❑ abuse: emotional, physical, sexual		❑ child custody battle	
❑ experimented with drugs		❑ family problems	
❑ chemical or alcohol dependency/parents		❑ problems with other kids	
❑ death of friend or loved one		❑ problems w/ parent-guardian	
❑ run away from home		❑ relocated/moved	
❑ family financial troubles		❑ academic problems	
❑ ADD/ADHD/Learning Disability		❑ school change	
❑ hyperactive		❑ school dissatisfaction	
❑ behavioral problems		❑ school problems	
❑ being suspended		❑ other:	

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

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

MEDICATIONS

List all medications your child takes for any reason. Place C beside drugs covered by opioid contract.

Name	Dose	Time Taken	Reason	Prescriber

DESCRIBE ANY ALLERGIES OR UNUSUAL REACTIONS TO ANY MEDICTIONS

CONDITION DESCRIPTORS

Some of the words below may describe your child's 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 the child's pain threshold (ability to tolerate pain)? (*check one*) ❑ Low ❑ Medium ❑ High

MEDICATIONS TAKEN FOR CONDITION

Please circle any medications your child has taken for the problems for which we are seeing the child.

Abilify	Bextra	Darvon	Fluoxetine	Lorazepam	Oxaprozin	Requip	Ultram
Acetaminophen	Boniva	Daypro	Fosamax	Lorcet	Oxy IR	Robaxin	Valium
Acyclovir	Bufferin	Decadron	Frova	Lortab	Oxcarbazepine	Sansert	Venlafaxine
Advil	BuSpar	Demerol	Gabapentin	Lunesta	Oxycodone	Savella	Verapamil
Aleve	Butazolodin	Depakote	Geodon	Lyrica	Oxycontin	Serax	Vicodin
Alprazolam	Butulinum	Deseryl	Gralise	Maxalt	Pamelor	Seroquel	Vioxx
Ambien	Cafergot	DHE 45	Halcion	Meclizine	Parnate	Serzone	Voltaren
Amerge	Calan	Dilantin	Haldol	Meloxicam	Paroxetine	Sinequan	Wellbutrin
Amitriptyline	Carbamazepine	Dolobid	Humira	Meperidine	Paxil	Skelaxin	Xanax
Anacin	Celebrex	Doxepin	Hydrocodone	Meprobamate	Percocet	Soma	Zanaflex
Anaprox	Celexa	Drixoral	Ibuprofen	Methotrexate	Percodan	Tavist	Zoloft
Antibiotics	Clonazepam	Duradrin	Imipramine	Midrin	Percogesic	Tegretol	Zolpidem
Aredia	Codeine	Effexor	Imitrex	Mobic	Periactin	Tizanidine	Zomida
Arthrotec	Compazine	Elavil	Inderal	Nabumetone	Phenaphen	Tofranil	Zomig
Ascriptin	Cortisone	Empirin	Indocin	Naprosyn	Phenytoin	Topamax	Zyprexa
Aspirin	Citalopram	Equagesic	Klonopin	Nardil	Prednisone	Toradol	
Ativan	Cyclobenzaprine	Excedrin	Lamictal	Nasacort	Propoxphene	Tramadol	
Axert	Cyclospasmol	Fioricet	Lexapro	Neurontin	Provigil	Tranxene	
Baclofen	Cymbalta	Fiorinal	Librium	Norflex	Prozac	Trazodone	
Beconase	Dalmane	Flexeril	Lithium	Norgesic	Relafen	Trileptal	
Benadryl	Darvocet	Flonase	Lodine	Norpramin	Remeron	Tylenol	

Others: (*list*)

GENERAL MEDICAL HISTORY

Circle pathology to indicate treatment for or history of the following. Give date diagnosed & details

AIDS	Easy Bleeding	Pregnancy Complications
Alcoholism	Epilepsy/Seizure Disorder	Prolonged Bleeding
Allergy (Adhesives)	Extreme Weight Changes (loss, gain)	Psychiatric Counseling
Allergy (Anesthesia)	Fibromyalgia/Lupus	Psychological Counseling
Allergy (Environment)	Frequent Mouth Ulcers	Radiation Therapy
Allergy (Latex)	Genital Problems	Respiratory Conditions/Breathing Trouble
Allergy (Medications)	Head or Neck Injury/Trauma	Rheumatic Fever
Alzheimer's Disease/Dementia	Heart Murmur	Ringing Ears/Tinnitus
Anemia	Heart Surgery	Scarlet Fever
Arthritis	Hepatitis	Sickle Cell Disease
Artificial Joints	Herpes (any location)	Sinus Problems
Asthma	HIV Positive	Skin Moles/Growths/Lesions
Bipolar Disorder	Hyperlipidemia	Skin Rashes
Birth Control Pills/Shots/Patches	Hypertension/High Blood Pressure	Stomach Ulcers
Bowel Problems	Hypoglycemia	Stomach/Digestive Problems
Cardiac Conditions/Heart Trouble	Joint Noises	Stroke
Circulatory Problems	Kidney Conditions	Thyroid Problems (hyper, hypo, tumor)
Cirrhosis of Liver	Mononucleosis	Tonsillitis
Constipation	Nerve Problems (viral, trauma, surgical)	Tuberculosis
COPD/Emphysema	Osteoporosis	Tumors/Growths/Cancers
Diabetes	Pacemaker	Vertigo/Dizziness

Details for Circled Items (Year Diagnosed, Treatment Needed):

List hospitalizations or surgeries (*of any type*)

Date	Reason	Treatment

Recent Medical Care: List conditions *other than orofacial* for were treated in the past two years.

Open Lock (Gets stuck wide open)

1st open locking occurred, please give date: month & year_____
Duration of 1st open locking? _____
Used force to close? _____, gentle manipulation? _____
Progression of open locking? frequency_____, duration_____, _____

Never Locked Open
_____
(Please Initial)

PARENT OR LEGAL GUARDIAN SIGNATURE

I understand that honest answers to the questions on this form are important to my child's health and my child's medical care. I have answered all questions to the best of my ability. I verify that all information about my child's 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.

Signature:	*Printed Name:*	*Date:*

