

# INTRODUCTION to CHRONIC PAIN OR DYSFUNCTION of the CHEWING SYSTEM

## Welcome

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

## Need to Understand Your Pain (Pre-exam questionnaire)

We begin our evaluation process by getting to know you and the pain or dysfunction you 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 pain or dysfunction through 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 pathology (pain or abnormal function). The better you communicate your 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 You (Pre-exam questionnaire)

You may think the need to know the patient behind the pain is just a catchy idea. If you understand 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 exam and to accurately diagnose your conditions, we need all the data related to each and every pain or dysfunction (can't open mouth wide) in the head, face and neck region.

## Previous Records (Pre-exam questionnaire)

To assist you at remembering the details of any past care, please contact previous healthcare providers to request relevant medical and/or dental records – no matter how old. This may include exam, clinical 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 healthcare costs down by arriving 15 minutes before your 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 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, and prepare a management and treatment plan especially for you. Prior to leaving the initial exam, you will schedule the second visit (consult) in approximately one week, where we review your 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 improved lifestyle.

**Important Significant Other:** It is important that anyone you deem as important and involved with your healthcare (spouse, sister, friend, child) attend the consult. The person that makes the financial and healthcare decisions in your family needs to attend the second appointment to understand what is involved to help you with pain reduction and/or improved jaw 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 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 the extra time needed to extract the information chairside. We accept many forms of payment (Visa, MasterCard, Discover, HAS 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 an understanding of your conditions and management protocol. Each patient is unique and has specific needs and the consultation is to outline specific needs that need to be addressed to successfully manage the pain and equip you 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: **(we cannot diagnose without all the detailed information)**(we cannot keep costs down with limited information) (if we have to collect it chairside the cost may go up)

- 1) **Completely** fill out pre-examination questionnaire (do not leave any section blank)
- 2) Separate different headaches on separate headache forms
- 3) Detail all accidents and traumas on separate forms (under additional optional forms on website)
- 4) Time line or evolution of pain needs all important details and events
- 5) Obtain any records from previous doctors or dentists that may help in exam & diagnosis (or provide us with a thorough list and pertinent numbers so that we may assist you with obtaining prior records)
- 6) Sign the patient consent form (so that we may converse with your doctors)
- 7) Return completed pre-exam questionnaire and get scheduled for your orofacial pain exam
- 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 a minimum of one hour for the doctor to get to know you and your pain during the examination
- 12) Read "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 business days in advance (business days are Monday – Thursday)
- 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)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

Office Use: Accepted by \_\_\_\_\_

Date \_\_\_\_\_

# Raleigh Facial Pain Center

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## NEW PATIENT INFORMATION

PLEASE PRINT LEGIBLY

Patient Full Name:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
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Nickname/Preferred Name:	Date of Birth:	Age:
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Social Security Number:	Drivers License Number/State:
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Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Engaged	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
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Home Address:	City/State:	ZIP Code:
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Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Email:
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Employer or College:	Job Title or Degree Pursued:	Work Hours:
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Work Address:	City/State:	ZIP Code:
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Spouse Name:	Work Phone: ( )	Cell Phone: ( )
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Employer:	Job Title:	Work Hours:
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Work Address:	City/State:	ZIP Code:
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Children's Names and Ages:
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Additional Contact ( <b>Required</b> )	Relationship	Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
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## HEALTHCARE PROVIDERS INFORMATION

Who may we thank for referring you?

Primary Care Physician:	Send reports to this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone: ( )
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Office Address:
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Date of Last Appointment:	Findings:
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Primary Dental Care Provider:	Phone: ( )
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Office Address:
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Date of Last Appointment:	Findings:
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Other Care Providers (Name, Specialty, Phone)
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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: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Open Access <input type="checkbox"/> Self-Funded <input type="checkbox"/> Supplemental <input type="checkbox"/> Other (please specify)			
Gatekeeper, if applicable:		Phone: (     )	
Policy Holder's / 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.

<b>Patient's signature:</b>	<b>Printed Patient Name:</b>	<b>Date:</b>
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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:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Message	Number:
Cell Phone:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Message <input type="checkbox"/> Text	
Work Phone:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Message	Number:
Fax:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number:
Email:	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

Primary Name:	Relationship:	
Email address:	Phone-cell:	
Secondary Name:	Phone:	Relationship:
<b>Patient's signature:</b>	<b>Printed Patient Name:</b>	<b>Date:</b>

### 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:

**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** \_\_\_\_\_ EXAMPLES: "jaw", "ear", "tongue", "mouth", "tooth" word)

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

**First Pain Ever**, 1<sup>st</sup> 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)    no pain    0    1    2    3    4    5    6    7    8    9    10    most pain ever  
Circle 0 if pain is not constant

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 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 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    |    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.**

## NECK DISCOMFORT DETAILS

Provide requested information if you have, or ever had, neck discomfort or pain. If you have ever sought treatment for neck pain – no matter how minor or how far in the past.

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

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

**First Noticed** Even Mild: \_\_\_\_\_ Describe 1<sup>st</sup> neck pain(time day, special circumstance, duration-intensity )

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)    no pain    0    1    2    3    4    5    6    7    8    9    10    most pain ever  
Circle 0 if not constant pain

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:**    **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 come & go, then became constant     Yes     No

Worse on workdays?     Yes     No    Has the pain inc freq, dura, intensity?     Yes     No

Does condition interrupt sleep?     Yes     No    Have you seen any providers for neck?     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     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)

List any and all providers seen for this condition, exam this pain, refer for pain, 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.**

**EVOLUTION OF NECK, JAW, HEAD PAIN**

We need to understand your pain or joint malfunction journey. **The main objective is to record the order of all events.** *Tell all when any of your symptoms occurred, when did jaw, neck or head pain start.* When did each symptom or area of symptom? 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-through-informative will save you money. Do your best to provide all details. **Copy & Use as an additional page if necessary.**

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	Knee surgery, locked jaw upon awakening	Right side stuck, pain and loud pop when forced
March 2008	Restricted opening every 2-3 weeks	Dentist Greg Brady referred to Dr Yount
Month-Year	Dates: soft diet, gum chew,	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 **each pain**?       Yes       No

## HEADACHE HISTORY (COPY PAGE FOR 2<sup>ND</sup> OR 3<sup>RD</sup> HEADACHE)\*\*\*\*

Report ALL HEADACHE LOCATIONS you have EVER HAD, no matter how minor, infrequent, or in the past. Describe **ONE & ONLY ONE** headache type &/or location per page. \_\_\_\_\_ (initial if NO HA, ever)

Have you ever had headache?  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

Date 1<sup>st</sup> headache -even mild Date(need answer):\_\_\_\_\_ Right:\_\_\_ Left \_\_\_, Switch side \_\_

Do you have warning (visual) before headache?  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 number in right time): \_\_\_ 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) no pain 0 1 2 3 4 5 6 7 8 9 10 most pain ever  
 Circle 0 if not constant headache

Average pain: (circle **ONE** number) no pain 0 1 2 3 4 5 6 7 8 9 10 most pain ever

My headaches are:  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 this headache worse?

What makes this headache better?

What is this headache's daily, weekly, or monthly pattern?

Describe light, balance, or sound sensitivity with this headache:

List all medications ever taken or currently taking for this headache (indicate if it reduces headache, eliminates headache, or did not work):

## 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 1<sup>st</sup> time- remember hearing?  Yes  No

Make sure year the click started is entered? (yellow box)  Yes  No Did sound change? For example, click to pop or gravelly sound.  Yes  No

No TMJ Noise	Initial Onset		Progression-Change			Current Noise			
Ever Int	Month & Year: ___/___/___		Month & Year: ___/___/___			Month & Year: ___/___/___			
	Sound		No pain	Sound		Pain?	Sound		Pain?
Right Only	<input type="checkbox"/> Pop	<input type="checkbox"/> Click	<input type="checkbox"/>	<input type="checkbox"/> Pop	<input type="checkbox"/> Click	<input type="checkbox"/> Yes	<input type="checkbox"/> gravel	<input type="checkbox"/> Click	<input type="checkbox"/> Yes
Left Only	<input type="checkbox"/> Pop	<input type="checkbox"/> Click	<input type="checkbox"/>	<input type="checkbox"/> Pop	<input type="checkbox"/> Click	<input type="checkbox"/> Yes	<input type="checkbox"/> gravel	<input type="checkbox"/> Click	<input type="checkbox"/> Yes
<b>Both Sides</b>	<input type="checkbox"/> Pop	<input type="checkbox"/> Click	<input type="checkbox"/>	<input type="checkbox"/> Pop	<input type="checkbox"/> Click	<input type="checkbox"/> Yes	<input type="checkbox"/> gravel	<input type="checkbox"/> Click	<input type="checkbox"/> Yes
How often occurs (Frequency)	<input type="checkbox"/> Intermittent <input type="checkbox"/> frequent <input type="checkbox"/> On all open			<input type="checkbox"/> Intermittent <input type="checkbox"/> most of time <input type="checkbox"/> on all open			<input type="checkbox"/> Intermittent <input type="checkbox"/> most time <input type="checkbox"/> on all open		
It can be heard (Loudness)	<input type="checkbox"/> Only by me <input type="checkbox"/> Others nearby <input type="checkbox"/> Across room			<input type="checkbox"/> Only by me <input type="checkbox"/> Others nearby <input type="checkbox"/> Across room			<input type="checkbox"/> Only by me <input type="checkbox"/> Others nearby <input type="checkbox"/> Across room		

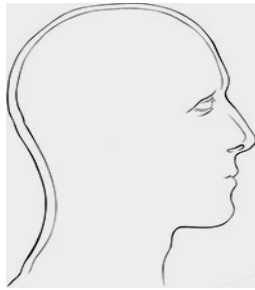


## PAIN LOCATION FOR HEAD, NECK, JAW, TOOTH, GUM

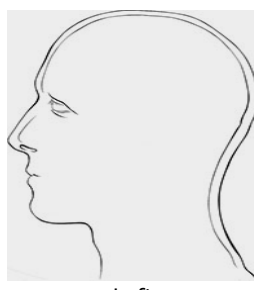
On the diagrams below, outline the affected area(s) and shade in those area(s).



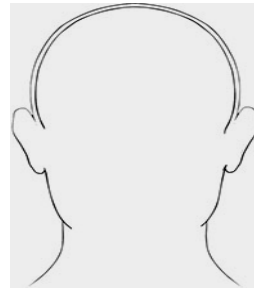
Front



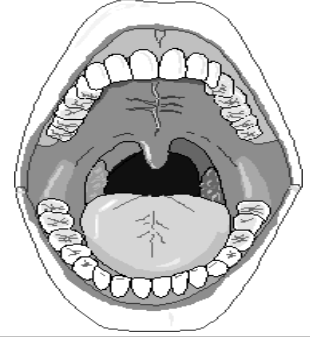
Right



Left



Back



### RESTRICTED OPENING (CAN'T OPEN ALL THE WAY)

Normal Opening	<input type="checkbox"/> 3 fingers	<input type="checkbox"/> 3.5 fingers	<input type="checkbox"/> 4 fingers	<input type="checkbox"/> <b>Never Had Restricted Opening</b>	<b>Initials:</b> _____
1 <sup>st</sup> Restricted Opening	<input type="checkbox"/> 1 fingers	<input type="checkbox"/> 1.5 fingers	<input type="checkbox"/> 2 fingers	<b>Date of 1<sup>st</sup> Restriction:</b> _____	
Which side feels restricted?	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Feels like:	<input type="checkbox"/> Overstretched	<input type="checkbox"/> Stuck/Blocked
<b>Episodes</b>	Per week _____	Month _____	Duration _____	<b>Pain Y N</b>	<b>Locked &amp; stayed locked (Date):</b> _____
Gentle Man	Force open	Manipulate	_____ (Circle one)	<b>What were you doing on 1<sup>st</sup> RO</b> _____	

### CENTRAL NERVOUS SYSTEM

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, tx or counseling, meds, duration med, 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?

What are your frustrations, concerns, or problems with chronic pain, chronic pain therapy, or any aspect of your pain journey?

What percentage of relief would be acceptable from treatment? \_\_\_\_\_%

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

### EXERCISE OR CARDIOVASCULAR THERAPY

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

Exercise Type: walk run treadmill swim bike    Time spent: \_\_\_\_\_    Distance: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs.    Height: \_\_\_\_\_ ft.    \_\_\_\_\_ in.    Waist: \_\_\_\_\_ in.    Other Exercise: \_\_\_\_\_

### COMPUTER ERGONOMICS (repeat for tablets, pads, or phones)

Monitor height	<input type="checkbox"/> above	<input type="checkbox"/> at	<input type="checkbox"/> below	eye level	Monitor location	<input type="checkbox"/> in front	<input type="checkbox"/> to right	<input type="checkbox"/> to left
Keyboard	<input type="checkbox"/> above	<input type="checkbox"/> at	<input type="checkbox"/> below	elbows	Average number of hours per day: _____			



## CONDITION DESCRIPTORS

Some of the words below may describe your condition. **Circle each and every word that describes your pain/dysfunction/condition.** Leave out any category that does not apply.

<b>1</b> Flickering Quivering Pulsing Throbbing Beating Pounding	<b>2</b> Jumping Flashing Shooting	<b>3</b> Prickling Boring Drilling Stabbing Lancinating	<b>4</b> Sharp Cutting Lacerating	<b>5</b> Pinching Pressing Gnawing Cramping Crushing
<b>6</b> Tugging Pulling Wrenching	<b>7</b> Hot Burning Scalding Searing	<b>8</b> Tingling Itchy Smarting Stinging	<b>9</b> Dull Sore Hurting Aching Heavy	<b>10</b> Tender Taut Rasping Splitting
<b>11</b> Tiring Exhausting	<b>12</b> Sickening Suffocating	<b>13</b> Fearful Frightful Terrifying Vicious	<b>14</b> Punishing Grueling Cruel	<b>15</b> Wretched Blinding
<b>16</b> Annoying Troublesome Miserable Intense Unbearable	<b>17</b> Spreading Radiating Penetrating Piercing	<b>18</b> Tight Numb Drawn Squeezing Tearing	<b>19</b> Cool Cold Freezing	<b>20</b> Nagging Nauseating Agonizing Dreadful Torturing

What is your pain threshold (ability to tolerate pain)? (check only one)

Low

Medium

High

## MEDICATIONS TAKEN FOR CONDITION

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

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

Topiramate

## DESCRIBE ANY ALLERGIES OR UNUSUAL REACTIONS TO ANY MEDICATIONS

## GENERAL MEDICAL HISTORY

Circle pathology and indicate year of onset. Give details of treatments in space provided below.  
Add a page if necessary.

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	Heart Murmur	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 Problems	Hypertension/High Blood Pressure	Stomach/Digestive Problems
Cardiac Conditions/Heart Trouble	Hypoglycemia	Stroke
Circulatory Problems	Joint Noises	Thyroid Problems (hyper, hypo, tumor)
Cirrhosis of Liver	Kidney Conditions	Tonsillitis
Constipation	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) \_\_\_\_\_

### List hospitalizations or surgeries (of any type)

Date	Reason	Treatment

**Recent Medical Care: List conditions *other than orofacial* for which you sought treatment in the past two years.**

## HEALTHCARE PROVIDER SEEN FOR ANY HEAD OR NECK PAIN

Please circle the healthcare providers you have seen for your present pain. **INCLUDE in TIME LINE**

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 # 5).**

## 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? IF so \_\_\_\_\_  Yes  No

Have your gums receded over the years around any teeth?  Yes  No If so, where? \_\_\_\_\_

Have you had your wisdom teeth removed? Yes, \_\_\_ yr remove Upper Lower Notes: \_\_\_\_\_

Have you ever broken, chipped, or cracked filling, crown, tooth, partial, implant? Tooth # \_\_\_\_\_ Year \_\_\_\_\_

Dates of Orthodontic Treatment: \_\_\_\_\_ to \_\_\_\_\_ and \_\_\_\_\_ to \_\_\_\_\_

Have you ever had failed: Implant Root canal Partial Bridge Veneer

## ORAL APPLIANCE

If you have had **more than one** appliance, professional made or OTC, copy this form for each one.

**Date** Appliance Acquired: (Mo & Yr) \_\_\_\_\_ **Who Prescribed/Provider:** \_\_\_\_\_

Mark ONLY ONE  Nightguard (protect joint)  Deprogrammer (NTI-anterior button)  Repositioning (move jaw forward)  Soft Biteguard (protects teeth)

<input type="checkbox"/> <b>Upper</b>	<input type="checkbox"/> Store-Bought(OTC)	<input type="checkbox"/> <b>Hard</b>	<input type="checkbox"/> <b>Soft</b>	<input type="checkbox"/> Full covers all teeth
<input type="checkbox"/> <b>Lower</b>	<input type="checkbox"/> Professionally Made	<input type="checkbox"/> <b>Hard outside, Soft inside</b>		<input type="checkbox"/> Partial-just posterior <input type="checkbox"/> Partial-just anterior

List all appliances, details, dates received, and results of appliance use in the Time Line (page 5).

## NUTRITION

Do you eat at least two balanced meals per day? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you on a soft diet? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take a daily multivitamin? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, start date: _____
Do you take any other supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any food sensitivities? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list: _____	If yes, list: _____
Do you drink alcohol after 6 PM? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink caffeine after 4 PM? <input type="checkbox"/> Yes <input type="checkbox"/> 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 (Gets stuck wide open, unable to close)

**1<sup>ST</sup> OPEN LOCKING:** DATE: MONTH & YEAR? \_\_\_\_\_ NEVER HAD AN OPEN LOCK \_\_\_\_\_ (INITIAL IF TRUE)

DURATION OF 1<sup>ST</sup> OPEN LOCKING? \_\_\_\_\_ USED FORCE TO CLOSE? \_\_\_\_\_ OR GENTLE MANIPULATION? \_\_\_\_\_

**PROGRESSION OF OPEN LOCKING: FREQUENCY** # \_\_\_\_\_ /WEEK OR MONTH OR YEAR (PLEASE CIRCLE ONE)

**DURATION:** \_\_\_\_\_ MINUTES \_\_\_\_\_ HOURS **DATE OF LAST OPEN LOCK?** \_\_\_\_\_

## PATIENT SIGNATURE

I understand that honest answers to questions on this form are important to my health and medical care. I have answered all questions to the **best of my ability**. I verify that all information about my 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. I understand that if I have not answered all questions thoroughly, I may be asked about these at the exam, which may increase the cost of my exam.**

Patient's signature:	Printed Patient Name:	Date: