Head, Neck, and Facial Pain Questionnaire

Patient Information:

Name:	
Date of Birth:	
Current Date:	
Gender:	☐ Male ☐ Female

Symptom Checklist:

For each symptom, please indicate Number (#1 = most severe, #2 = less severe, #3 = least severe, no number if not a symptom), Frequency of pain (1–4), and Intensity of pain (1–10).

Symptom	*Number*	*Frequency (1-4)*	*Intensity (1-10)*
Jaw pain			
Morning head pain			
Jaw clicking			
Ringing in the ears			
Jaw locking			
Dizziness			
Limited mouth opening			
Frequent heavy snoring			
Facial pain			
Pain in/around ear			
Neck pain			
Pain when chewing			
Headaches			
Migraines			

Additional Symptoms: Please check all that apply

Mouth And nose

☐ Burning tongue
☐ Frequent biting of cheek RIGHT or LEFT
☐ Frequent snoring
☐ Broken teeth
☐ Teeth clenching
☐ Dry mouth
☐ Chronic sore throat
☐ Constant feeling of a foreign object in throat
☐ Difficulty in swallowing

Ear Related Conditions

☐ Buzzing in the ears
☐ Tinnitus (ringing)
☐ Ear pain
☐ Ear congestion
☐ Hearing loss RIGHT or LEFT
☐ Recurrent ear infections
☐ Pain behind the ear RIGHT or LEFT

Jaw Pain

☐ Jaw pain on opening RIGHT or LEFT
☐ Jaw pain while chewing RIGHT or LEFT
☐ Jaw pain at rest RIGHT or LEFT
☐ Jaw popping RIGHT or LEFT
☐ Jaw clicking RIGHT or LEFT
☐ Jaw locks closed
☐ Jaw locks open
☐ Teeth grinding

Neck & Back Related

☐ Neck pain
☐ Back pain (upper/middle/lower)
☐ Shoulder pain/stiffness
☐ Sciatica
☐ Scoliosis
☐ Numbness in the hands or fingers
☐ Chronic sore throat
☐ Constant feeling of a foreign object in throat
☐ Difficulty in swallowing
☐ Limited movement of neck
☐ Swelling in the neck
☐ Swollen glands
☐ Tingling in the hands or fingers
☐ Chronic sinusitis

Eye Related

☐ Blurred vision
☐ Pain/pressure behind eyes
☐ Swelling around eyes

History of Symptoms

Is there anything that makes your pain or discomfort worse?

_____

_____

Is there anything that makes your pain or discomfort better?

_____

_____

What other information is important regarding the pain or condition?

_____

_____

History of any Treatment:

Practitioner's Name	Specialty	Treatment	Approx. Date

History of Accident:

If your pain/condition is related to an accident or traumatic incident, please complete this section.

Date of Accident/Incident: ____/____/_____

THE PATIENT BELIEVES THE CAUSE OF THE PAIN OR CONDITION TO BE:

- ☐ A motor vehicle accident
- ☐ A motorcycle accident
- ☐ A work-related incident
- ☐ A playground incident
- ☐ Hit by an object
- ☐ Hit an object
- ☐ An illness
- ☐ An injury
- ☐ A sports related incident
- ☐ A fight
- ☐ A fall
- ☐ An accident
- ☐ Orthodontics
- ☐ Dental procedures
- ☐ Whiplash
- ☐ Other:_____

Role (check one): ☐ Driver ☐ Passenger ☐ Pedestrian ☐ At work ☐ Other: _____

IF IN A VEHICLE, WHERE WAS THE VEHICLE HIT?

- ☐ At the front-end
- ☐ Head on
- ☐ At the rear end
- ☐ On driver's side
- ☐ At the front right area
- ☐ On passenger's side
- ☐ At the front left area
- ☐ At the rear right area
- ☐ At the rear left area

Other:_____

INDICATE IF THERE WAS ANY TRAUMA:

- ☐ Forehead
- ☐ Top of head
- ☐ Back of head
- ☐ Face
- ☐ Teeth
- ☐ Chin
- ☐ Jaw
- ☐ Side of head

Other:_____

FORCIBLY STRUCK THE:

- ☐ Steering wheel
- ☐ Headrest
- ☐ Passenger's side door
- ☐ Windshield
- ☐ Seat
- ☐ Driver's side door
- ☐ Passenger's side window
- ☐ Roof
- ☐ Driver's side window
- ☐ Interior of the car

Other:_____

Pain History:

Please rate pain severity on scale of 0–10 (0 = No Pain, 10 = Worst Imaginable).

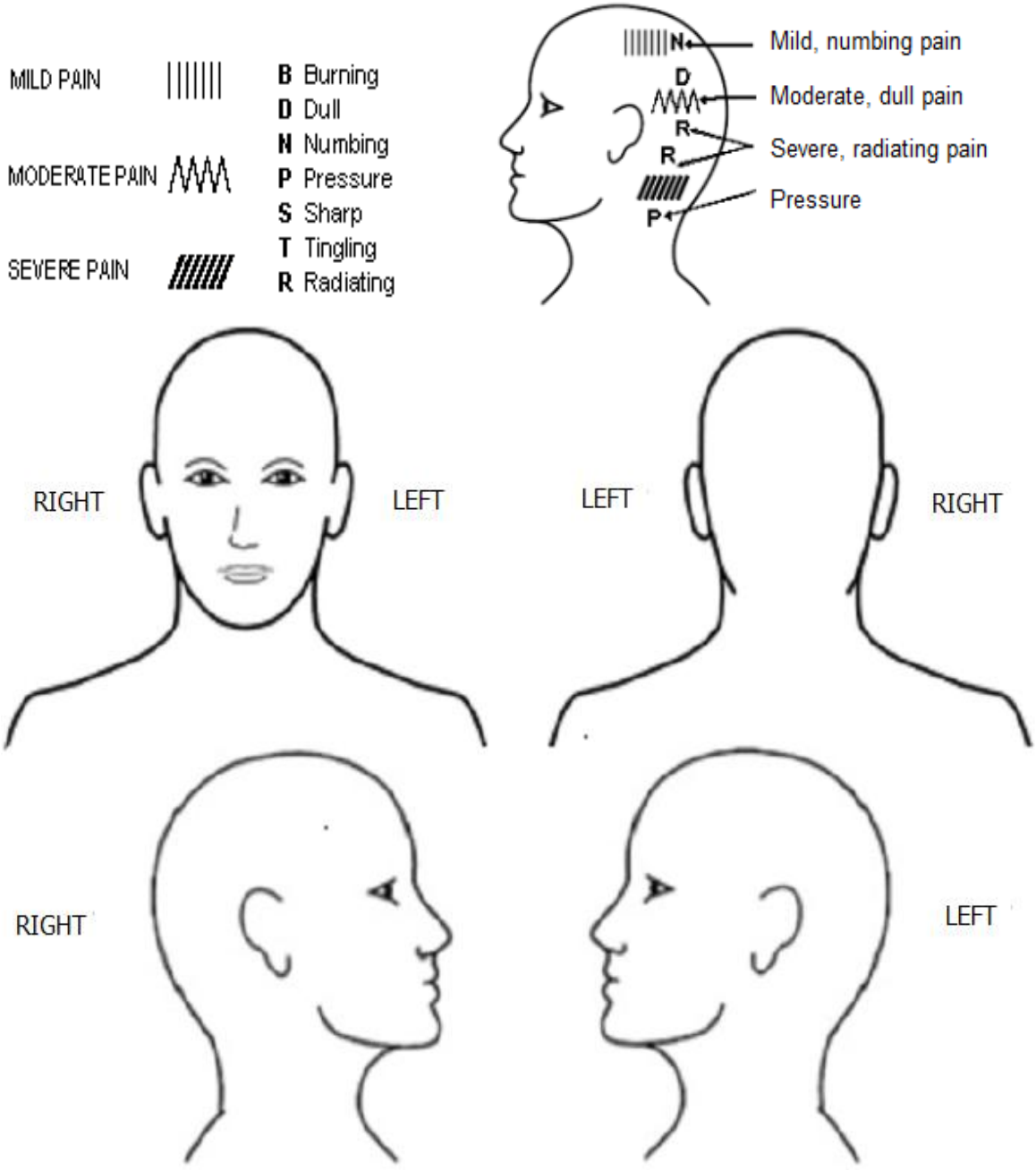
Jaw Pain:	____/10	☐ Occasional (0–3/mo) ☐ Frequent (3–6/mo) ☐ Constant
Headaches:	____/10	☐ Occasional (0–3/mo) ☐ Frequent (3–6/mo) ☐ Constant
Neck Pain:	____/10	☐ Occasional (0–3/mo) ☐ Frequent (3–6/mo) ☐ Constant
Facial Pain:	____/10	☐ Occasional (0–3/mo) ☐ Frequent (3–6/mo) ☐ Constant

Duration: ☐ Seconds ☐ Minutes ☐ Hours

Associated Symptoms:

- ☐ Dizziness
- ☐ Sensitivity to noise
- ☐ Double vision
- ☐ Throbbing
- ☐ Fatigue
- ☐ Vomiting
- ☐ Nausea
- ☐ Burning
- ☐ Sensitivity to light (photophobia)

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY



Signature & Consent

I certify that the medical history information is complete and accurate.

Patient Signature: _____ Date: _____