Patient Name:

CRANIOFACIAL PAIN QUESTIONNAIRE

This questionnaire was designed to provide important information regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take time to answer each question as completely and honestly as possible.

PATIENT INFORMATION:

Circle One: Mr / Mrs / Ms / Dr **Circle : MALE FEMALE**

NAME:

____

Last First Middle Initial

ADDRESS: ____

CITY / STATE / ZIP: ____

HOME PHONE:____________________ **BUSINESS PHONE:** ______________

CELL PHONE: _____________________________ **AGE:** ______

EMAIL ADDRESS: __________________________________

SOCIAL SECURITY NUMBER: ______ - ______ - ______ **DATE OF BIRTH:** ____/____/____

RESPONSIBLE PARTY: _________________________________
PHONE: ________________________
ADDRESS: ____
CITY / STATE/ZIP: __________________________________
EMPLOYER: ______________________________________
ADDRESS: __________________________

PRIMARY MEDICAL INSURANCE: ____________________________
POLICY HOLDER: ________________________________ **POLICY HOLDER DOB:** __________________
MEMBER ID______________________________________**INSURANCE PHONE #**______________________

- **Your Medical Insurance may help to pay for your care. However, there is no guarantee that your insurance will pay for any part of your evaluation or care. You are responsible for any fees that your insurance does not pay, regardless of the reason that they do not pay.**
- **The charge for your first visit with us will be $310 which includes a panoramic radiograph and evaluation. The fee for basic follow-up visits is $165.**
- **Most patients need 2 appointments to determine a plan that may help them.**

COASTAL VIRGINIA
SLEEP SOLUTIONS

Patient Name:

Below, please RANK your top FOUR complaints with #1 being the most important, #2 the next important, etc	CHIEF COMPLAINTS	FREQUENCY 1: Seldom 2: Occasional 3: Frequent 4: Every Day	INTENSITY 0-10 0 = No Pain 10 = Most Severe Pain
	Back Pain		
	Dizziness		
	Ear Congestion		
	Ear Pain		
	Eye Pain		
	Facial Pain		
	Fatigue		
	Headaches		
	Jaw Joint Noises		
	Jaw Locking		
	Jaw Pain		
	Limited Mouth Opening		
	Muscle Twitching		
	Neck Pain		
	Pain when Chewing		
	Ringing in the Ears		
	Shoulder Pain		
	Sinus Congestion		
	Throat Pain		
	Tooth Pain or Tooth ache		
	Visual Disturbances		
	(Anything else?)		
	(Anything else?)		

Patient Name:

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED YOU TO HAVE AN ALLERGIC REACTION:

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN: (including over the counter medications, vitamins, and supplements) AND THE REASON FOR TAKING THE MEDICATION:

Medication:	Reason for Taking:

REFERRED BY: ____

( )
____
ADDRESS CITY STATE ZIP PHONE NUMBER

Date of most recent DENTAL evaluation:______________________________
Reason:________________________________
NAME of FAMILY DENTIST: __________________________
NAME OF DENTAL PRACTICE:___________________________

Date of most recent MEDICAL evaluation:______________________________
Reason:________________________________
NAME of FAMILY PHYSICIAN / PCP : __________________________
NAME OF MEDICAL PRACTICE:___________________________

Patient Name:

Have you ever had an MRI or CT Scan specifically to look at your jaw joints?

If yes, WHEN: ____

If yes, LOCATION OF MRI CENTER:_____________________________________

Are you pregnant, OR is there any chance that you are pregnant: YES NO

MEDICAL HISTORY (Check either YES or NO for ALL conditions and specify dates next to conditions marked YES)

Y❑ N❑ Adenoids removed
Y❑ N❑ Tonsils removed
Y❑ N❑ Anemia
Y❑ N❑ Arteriosclerosis
Y❑ N❑ Asthma
Y❑ N❑ Autoimmune disorders
Y❑ N❑ Bleeding easily
Y❑ N❑ High Blood Pressure
Y❑ N❑ low Blood Pressure
Y❑ N❑ Bruising easily
Y❑ N❑ Cancer
Y❑ N❑ Chemotherapy
Y❑ N❑ Chronic fatigue
Y❑ N❑ Cold hands & feet
Y❑ N❑ Immune system disorder
Y❑ N❑ Injury to face
Y❑ N❑ Injury to mouth
Y❑ N❑ Injury to neck
Y❑ N❑ Injury to teeth
Y❑ N❑ Insomnia
Y❑ N❑ Intestinal Disorder
Y❑ N❑ Jaw Joint surgery
Y❑ N❑ Kidney Problems
Y❑ N❑ Liver disease
Y❑ N❑ Meniere's Disease
Y❑ N❑ Menstrual cramps
Y❑ N❑ Multiple Sclerosis
Y❑ N❑ Muscle aches
Y❑ N❑ Muscle shaking (tremors)
Y❑ N❑ Thyroid Problems

Y❑ N❑ Current Pregnancy
Y❑ N❑ Depression
Y❑ N❑ Diabetes
Y❑ N❑ Difficulty Concentrating
Y❑ N❑ Dizziness
Y❑ N❑ Emphysema
Y❑ N❑ Epilepsy
Y❑ N❑ Excessive Thirst
Y❑ N❑ Fluid retention
Y❑ N❑ Frequent cough
Y❑ N❑ Frequent Illness
Y❑ N❑ Frequent stressful situations
Y❑ N❑ General Anesthesia
Y❑ N❑ Muscle Spasms or Cramps
Y❑ N❑ Muscular Dystrophy
Y❑ N❑ Needing Extra pillows to help Breathing at night
Y❑ N❑ Nervous system Irritability
Y❑ N❑ Nervousness
Y❑ N❑ Neuralgia
Y❑ N❑ Osteoarthritis
Y❑ N❑ Ovarian cysts
Y❑ N❑ Parkinson's disease
Y❑ N❑ Poor circulation
Y❑ N❑ Prior orthodontic treatment
Y❑ N❑ Psychiatric care
Y❑ N❑ Radiation treatment
Y❑ N❑ Rheumatic fever
Y❑ N❑ Rheumatoid arthritis

Y❑ N❑ Glaucoma
Y❑ N❑ Gout
Y❑ N❑ Hay Fever
Y❑ N❑ Hearing Impairment
Y❑ N❑ Heart Murmur
Y❑ N❑ Heart Disorder
Y❑ N❑ Heart Pacemaker
Y❑ N❑ Heart Palpitations
Y❑ N❑ Heart Valve Replacement
Y❑ N❑ Hemophilia
Y❑ N❑ Hepatitis
Y❑ N❑ Hypoglycemia
Y❑ N❑ Scarlet fever
Y❑ N❑ Shortness of breath
Y❑ N❑ Sinus problems
Y❑ N❑ Skin disorder
Y❑ N❑ Sleep apnea
Y❑ N❑ Sleep disorders
Y❑ N❑ Slow healing sores
Y❑ N❑ Speech difficulties
Y❑ N❑ Stroke
Y❑ N❑ Swollen, stiff, or Painful Joints
Y❑ N❑ Tendency for frequent colds
Y❑ N❑ Tendency for ear infections
Y❑ N❑ Tendency for sore throats
Y❑ N❑ Tired muscles
Y❑ N❑ Tuberculosis
Y❑ N❑ Tumors
Y❑ N❑ Urinary disorders
Y❑ N❑ Wisdom teeth extraction

Y❑ N❑ Other medical/Dental History ____

Patient Name:

In your own words, what is your concern/ complaint today:

___

___

If you are experiencing pain, please describe where on your body this pain is located. If there you have pain in more than one area, please include each area of concern:

___

___

___

When did the pain first begin?

___

What do you believe is the cause of your condition?

		DATE	DESCRIPTION OF INJURY
________	Motor Vehicle Injury	___/___/___	___
________	Workers Compensation Injury	___/___/___	___
________	Accidental Injury	___/___/___	___
________	Disease/Injury	___/___/___	___
________	Unknown Cause	___/___/___	___
Other: ___		___/___/___	___

Is your pain or problem part of any current or future lawsuit? ___

Please describe the quality of your pain?
(Examples may include: stabbing, sharp, throbbing, aching, hot)

___

Is the pain constant or intermittent:

___

Does it radiate to other areas of the body? If so, where?

___

Please rate your pain on a scale of 0-10 (0= no pain, 10= worst imaginable pain)

- Pain at it's best ___
- Pain at it's worst ___

Patient Name:

Are there any certain situations or actions that make the pain worse? If so, please describe.

____

____

____

Which of the following have you tried to help your pain/condition? On a scale of 1-5 please rate of effective each was in relieving your symptoms (1-not effective, 2-slightly effective, 3-moderately effective, 4-very effective, 5-most effective)

					Medications (including Advil, etc)	
❑ Wearing night guard	1 2 3 4 5	❑ Massage	1 2 3 4 5			
❑ Stretching exercise	1 2 3 4 5	❑ Relaxation	1 2 3 4 5		_________________	1 2 3 4 5
❑ Ice/moist heat	1 2 3 4 5	❑ Biofeedback	1 2 3 4 5		_________________	1 2 3 4 5
❑ Physical therapy	1 2 3 4 5	❑ Pain management	1 2 3 4 5		❑Other:	
					_________________	1 2 3 4 5

Describe and give approximate dates of any other trauma to ANY part of your body. INCLUDE any accidents, sports injuries, or other injuries that could have affected the head and neck (even as a child):

____

____

____

____

____

____

____

____

____

____

What other information is important for us to know about your pain condition?

____

____

____

____

____

____

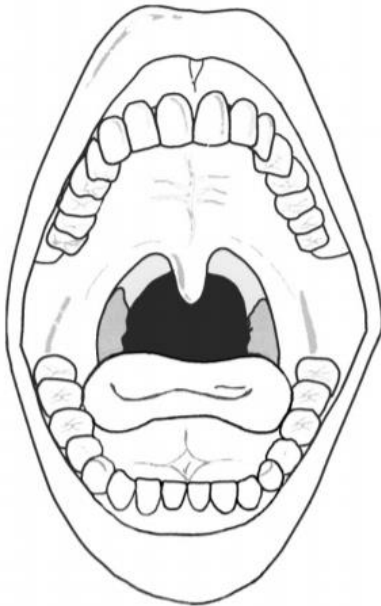
____

COASTAL VIRGINIA
SLEEP SOLUTIONS

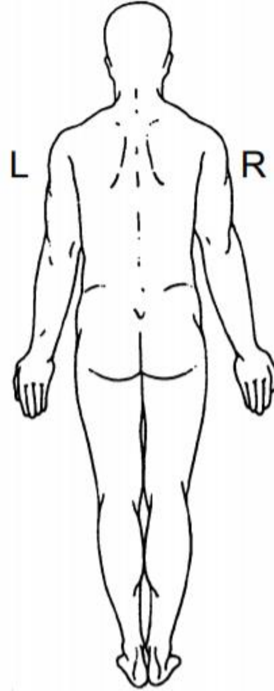
Patient Name:

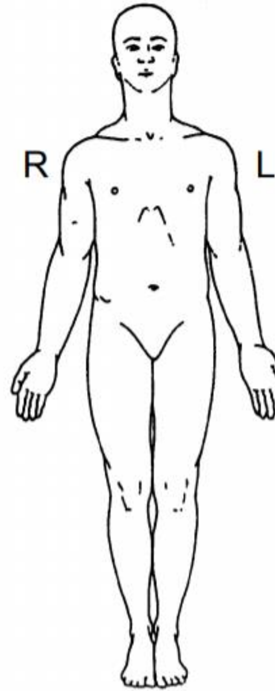
PAIN DRAWING

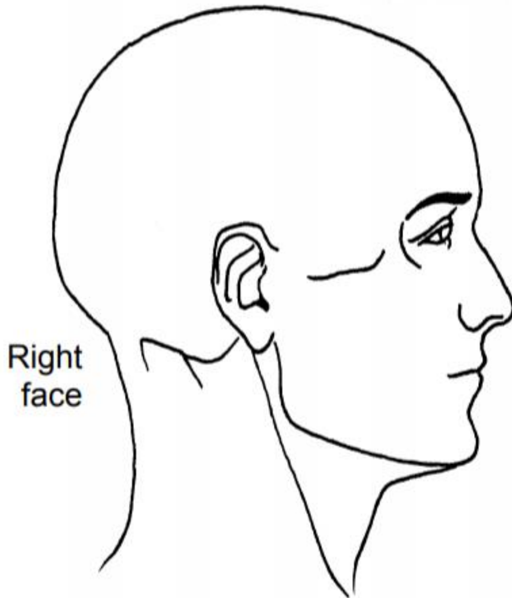
Indicate the location of ALL of your different pains by shading in the area, using the diagrams that are most relevant. If there is an exact spot where the pain is located, indicate with a solid dot (●). If your pain moves from one location to another, use arrows to show the path.



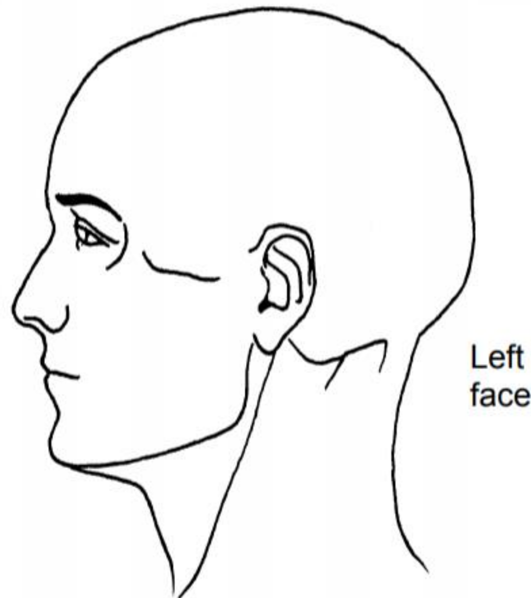
Mouth and teeth







Right face



Left face

Patient Name:

Have you seen any of the following doctors for <u>any</u> reason? Please describe when and what was done

	NAME	WHEN	WHY	ANY RELIEF?
ENT (Ear, Nose, Throat)				
Neurologist				
Neurosurgeon				
Chiropractor				
Psychiatrist / Psychologist				
Sleep Medicine				
PT (Physical Therapist)				
Massage Therapist				
Acupuncture				
Orthopedic Surgeon				
Orthodontist				
General Dentist				
Pain Doctor / Pain Medicine Specialist				
Counseling or Therapy				

COASTAL VIRGINIA
SLEEP SOLUTIONS

Patient Name:

FITNESS AND FAMILY

1. General Health: are you physically active and able to do everything you want to do? _______
   If not, Why? ____
   ____

2. Have any of these family members ever been treated for any of these conditions: **(circle either YES or NO for ALL of the following)**

	Mother / father	Brother / sister	child
Stroke	YES / NO	YES / NO	YES / NO
Heart Disease	YES / NO	YES / NO	YES / NO
Heart Attack	YES / NO	YES / NO	YES / NO
Diabetes	YES / NO	YES / NO	YES / NO
Tonsil problems	YES / NO	YES / NO	YES / NO
Adenoid problems	YES / NO	YES / NO	YES / NO
Ear infections	YES / NO	YES / NO	YES / NO
Strep throat or throat infections	YES / NO	YES / NO	YES / NO
Multiple headaches	YES / NO	YES / NO	YES / NO
Mental health	YES / NO	YES / NO	YES / NO
Depression	YES / NO	YES / NO	YES / NO
Anxiety	YES / NO	YES / NO	YES / NO
Obsessive-Compulsive Disorder	YES / NO	YES / NO	YES / NO
Attention-Deficit / Hyperactivity Disorder	YES / NO	YES / NO	YES / NO
Sleep Disorders	YES / NO	YES / NO	YES / NO
Trouble sleeping	YES / NO	YES / NO	YES / NO
GERD / Gastric reflux	YES / NO	YES / NO	YES / NO
Heartburn	YES / NO	YES / NO	YES / NO
TMD / TMJ problems	YES / NO	YES / NO	YES / NO

3. Do you take any supplements: ____
4. Do you use Caffeine: ____
5. History of smoking: ____
6. History of alcohol use: ____
7. History of illegal drug use: ____
8. How often do you Exercise or engage in physical activity: daily / weekly / monthly
   - What exercises or activities do you engage in:
     ____
9. What are you favorite leisure activities / ways to relax? ______________________________
   - How frequently?____
     ____

COASTAL VIRGINIA
SLEEP SOLUTIONS

Patient Name:

10. Do you know, or has anyone else reported (at any time!) that you snore?

If YES:

- how many nights per week do you snore? ________________________________
- How loud is your snoring? ____
- Is your snoring loud enough to be heard through a closed door? _____________
- Has your snoring interrupted the sleep of someone else? ___________________
- Are you separated from your bed partner due to your snoring? ______________

11. Do you know, or has anyone else reported, that you clench and grind your teeth? ____________

12. Do you get headaches?

If YES:

- What time of day? ____
- What part of your head? ____
- How frequently? ____
- What makes the headaches better? _____________________________________
- What makes the headaches worse? ______________________________________

13. Quality of Sleep

- Go to bed time at night: ____
- Fall asleep time at night: ____
- What time get up in morning to start day: ____________________________________
- How many awakenings during night: ____
- Why waking up: ____
- How long to go back to sleep: ____
- Daytime naps? How many / how long / what time of day___________________________
- Usual Sleep Position: ____
- Wake gasping / choking: ____
- Witnessed Apneas: ____
- Daytime Drowsiness: ____
- Do you feel Refreshed upon waking: ____

Patient Name:

I certify, to the best of my ability, that the information on these forms is accurate.

Patient Signature: ____Date:_____________________

Patient Printed Name: ____

Reviewed by Team Member: ____
Date:__________________