SLEEP APNEA & TMJ

Sleep Apnea & Snoring
TMJ Disorders
Head & Facial Pain

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 classifying a diagnosis and determining the nature of your problem. Please take time to answer each question as completely and honestly as possible.

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. Today's Date: _____

NAME: _____ First / Middle Initial / Last

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____ ☐ Marital ☐ Primary

CELL PHONE: _____ EMAIL ADDRESS: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____ AGE: _____

RESPONSIBLE PARTY: _____ PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYER: _____ ADDRESS: _____

PRIMARY INSURANCE: _____	SECONDARY INSURANCE: _____
POLICY HOLDER: _____	POLICY HOLDER: _____
POLICY HOLDER DOB: _____	POLICY HOLDER DOB: _____

☐ Please check here if you are pregnant or think you might be, and let our office know.

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please number your complaints with the most important of the two complaints as 1.	2. Please rate your complaints for frequency and severity. Frequency: 1 = 10% (Rarely) to 10 = 100% (Constant). Severity: 1 = 10% (Mild) to 10 = 100% (Severe).

Number	Frequency (1-10)	Severity (1-10)	Number	Frequency (1-10)	Severity (1-10)
____ Back pain			____ Mouth Swelling		
____ Dizziness			____ Neck Pain		
____ Ear Congestion			____ Pain after Chewing		
____ Ear Pain			____ Ringing in the Ears		
____ Eye Pain			____ Shoulder Pain		
____ Facial Pain			____ Sinus Congestion		
____ Fatigue			____ Throat Pain		
____ Headaches			____ Visual Disturbances		
____ Jaw Joint Noises			Write in any other symptoms:		
____ Jaw Locking					
____ Jaw Pain					
____ Limited Mouth Opening					

Patient Name: _____ Date: _____

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