NOVA Orofacial Pain, TMD & Dental Sleep Medicine
8987 Hersand Dr.
Burke, VA 22015

HEAD AND NECK PAIN EVALUATION FORM

Date: _____ **Name:** _____

Date of Birth: _____ **Age:** ___ **Height:** ___ **Weight:** ___ **Dominant Hand: Right** ____ **Left** ____

Address: _____ **City & State:** _____ **Zip Code:** _____

Mobile: _____**Other Phone #**_____ **H - W (circle one)**

Email: _____

Medical Insurance: _____ **Dental Insurance:** _____

I. ***Referring Doctor and other Doctors you would like to have reports sent to;***

Name of Doctor	Specialty	Phone Number	Fax Number	Address

II. Understanding Your Pain

A. Describe in ***your own words*** the problem(s) you would like help with:

_____
_____
_____
_____

B. Is nausea associated with your pain? Yes___ No ___
Is vomiting associated with your pain? Yes ___ No ___
Does your pain increase with bright lights? Yes ___ No ___
Does your pain increase with loud noises? Yes ___ No ___
Does physical activity make your pain: Better worse no change (circle one)
Do you get an aura? (flashing lights, zigzags, blindness, smells)? Yes__ No__ If yes describe: _____
Does your pain wake you up from sleep? Yes___ No___
Does your pain keep you from falling asleep? Yes___ No___
Do any of your family members have the same or similar pain problems? Yes___ No___
Do any of these occur with your pain (circle all that apply):
Eyelid drooping Redness of the eye(s) Tearing of the eye(s) Nasal stuffiness Face sweating
Do you have difficulty opening or closing your mouth? Yes___ No___

Do you hear clicking or popping in your jaw points? Yes___ No___

B. Is your pain ◻ Continuous or ◻ Intermittent?

C. If your pain is intermittent how often does it occur?

- ◻ Several times a day
- ◻ Once per day
- ◻ Several times per week
- ◻ Once per week
- ◻ Less than once per week
- ◻ Never
- ◻ Other

D. How long does your pain last?

- ◻ None
- ◻ Seconds
- ◻ Minutes
- ◻ Hours
- ◻ Days
- ◻ Weeks
- ◻ Continuous

E. Circle a number below to indicate your **highest** pain intensity over the past week

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain	Most Intense Pain		

F. Circle a number below to indicate your **lowest** pain intensity over the past week

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain	Most Intense Pain		

G. Circle a number below to indicate your **usual** pain intensity over the past week

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain	Most Intense Pain		

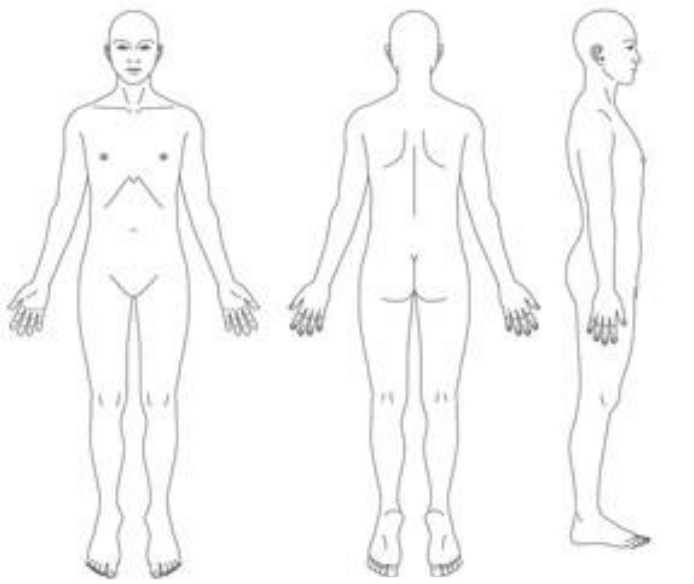
H. Below is a list of words that may describe your pain:

Please rate each word on the scale of 0-3 point scale to describe your pain.

	None	Mild	Moderate	Severe
Throbbing	0)_____	1)_____	2)_____	3)_____
Shooting	0)_____	1)_____	2)_____	3)_____
Stabbing	0)_____	1)_____	2)_____	3)_____
Sharp	0)_____	1)_____	2)_____	3)_____
Cramping	0)_____	1)_____	2)_____	3)_____
Gnawing	0)_____	1)_____	2)_____	3)_____
Hot-Burning	0)_____	1)_____	2)_____	3)_____
Aching	0)_____	1)_____	2)_____	3)_____
Heavy	0)_____	1)_____	2)_____	3)_____
Tender	0)_____	1)_____	2)_____	3)_____
Splitting	0)_____	1)_____	2)_____	3)_____
Tiring-	0)_____	1)_____	2)_____	3)_____
Exhausting	0)_____	1)_____	2)_____	3)_____
Sickening	0)_____	1)_____	2)_____	3)_____
Fearful	0)_____	1)_____	2)_____	3)_____
Punishing –	0)_____	1)_____	2)_____	3)_____
Cruel	0)_____	1)_____	2)_____	3)_____

Other: _____ Describe: _____

I. Please indicate where you have pain:



J. What makes the pain **WORSE?** Be specific.

_____
_____

K. What makes the pain **BETTER?** Be specific.

_____
_____

III. *Effects of Pain*

1. Circle the number of how much your pain has interfered with your activities this **past week.**

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain	Most Intense Pain		

2. Circle the number of how bothered or upset you have been about the pain in the **past week.**

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain	Most Intense Pain		

3. Circle the number to indicate how much your pain has interfered with your sleep this **past week.**

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain	Most Intense Pain		

IV. *Current Medications*

List **ALL** medicines you are **CURRENTLY** taking for medical and pain problems (including prescribed, over-the-counter, herbs, vitamins): (write on the back of this sheet if necessary)

Name	Pill Strength	Number of times per day	Prescribing Doctor	Date Started

Pharmacy Name and Phone# _____

V. History of Your Pain

A. When did your pain start? _____

B. When did your pain become a problem? _____

C. How many times have you gone to the emergency room for pain in the last year? _____

D. What event or events led to your present pain: ☐ Accident ☐ Other Injury

☐ Other Disease ☐ Cancer ☐ No Obvious Cause ☐ Surgery Other:_____

E. What do YOU think is the cause of your pain?

_____

_____

_____

_____

VI. Previous Doctors

Have you ever been evaluated at a pain center? Yes___ No___

If Yes list the doctors name _____

Facility Name and Address _____

List **ALL** doctors you have seen for your pain problem (continue on the back of this page if needed).

Date	Name	Specialty	Address/Phone/Fax

VII. *Diagnostic Tests (MRI, CT SCANS, X-RAYS, BLOOD TESTS, ETC.):*

Please list, in chronological order, all tests and x-rays preformed to evaluate your pain:

Date	Tests	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VIII. *Previous Treatments:*

Indicate which of the following treatments you have tried for your problem:

- ☐ Antidepressants ☐ Acupuncture ☐ Psychotherapy ☐ Homeopathy ☐ Narcotics ☐ Chiropractor
- ☐ Biofeedback ☐ TENS ☐ Nerve Blocks ☐ Massage ☐ Relaxion Training
- ☐ Exercise Program ☐ Traction ☐ Physical Therapy ☐ Hypnosis ☐ Other (List) _____

IX. *Previous Medications*

Name of Medicine	Dose	Dates of Use	Helpful?	Reasons for Stopping
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

X. *Past Medical Problems, Surgeries, Hospitalizations, and Injuries:*

List any operations, hopitalizations, or injuries you have ever had.

Year	Describe (reason for surgery/hospitalizations or type of injury)	Hospital	Doctor
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____

XI. *Allergies (if No Known Allergies check here)*

List all allergies to medications and the reaction you had to any medicine (or any other allergies) :

Medicine	Reaction	Medicine	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

XII. *Review of Systems*

Please check if you currently have had any of the following (**please indicate next to the item when the problem occurred).**

A. General

- ☐ Weight Loss
- ☐ Poor Appetite
- ☐ Severe Fatigue/Low Energy
- ☐ Cancer

B. Hematologic

- ☐ Anemia
- ☐ Easy Bruising
- ☐ Bleeding Disorder
- ☐ Taking Blood Thinners
- ☐ Blood Transfusion

C. Skin

- ☐ Rash
- ☐ Nail Changes
- ☐ Bumps/Nodules

D. Head and Neck

- ☐ Headaches
- ☐ Visual Changes
- ☐ Mouth Problems
- ☐ Neck Pain
- ☐ TMJ Problems

E. Cardiac

- ☐ Exercise Limitations
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ High or Low Blood Pressure (circle one)
- ☐ Circualtion Problems
- ☐ Ankle Swelling

F. Pulmonary

- ☐ Shortness of Breath
- ☐ Cough
- ☐ Asthema or Bronchitis
- ☐ Lung Disease
- ☐ Sleep Apnea
- ☐ Snoring

G. Endocrime

- ☐ Diabetes
- ☐ Thyroid Problems

H. Gastrointestinal

- ☐ Abdominal Pain
- ☐ Nausea or Vomiting (circle)
- ☐ Constipation
- ☐ Diarrhea
- ☐ History of Ulcers or Heart Burn (circle)

I. Genitourinary

- ☐ Frequent or Hesitant Urination
- ☐ Pain with Urination

- ☐ Blood in Urine
- ☐ Incontinence
- ☐ Sexual Dysfunction

J. Musculoskeletal

- ☐ Arthritis Type: _____
- ☐ Osteoporosis
- ☐ Muscle Pain
- ☐ Muscle Wasting
- ☐ Fractures Where on Body: _____

K. Neurologic

- ☐ Numbness
- ☐ Weakness
- ☐ Falling
- ☐ Stroke
- ☐ Seizures
- ☐ Memory Loss
- ☐ Loss of Balance

L. Infectious Diseases

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ Hepatitis Type: _____
- ☐ HIV / AIDS
- ☐ Herpes Location: _____
- ☐ Shingles
- ☐ Post-herpetic Neuralgia

M. Gynecologic

- ☐ Pregnant When: _____
- ☐ Post-Menopausal, Last Period: _____

XIII. ***Medical Problems: Please indicate any other medical problems that are not listed above.***

_____

_____

XIV. ***Habits***

A. Smoking: Yes___ No___ Quit___ Number of Packs/Day___ Number of Years Smoked___
B. Alcohol Use: None___ Occasional___ Daily___ How Many Drinks Per Week? _____
C. Recreational Drugs: Current use? Yes__ No___
__Cocaine __ Amphetamine __ Marijuana __ Heroin __ Other
D. Coffee/Tea/Caffeine: Number of Cups/Day _____
E. Clenching teeth: Yes___ No___ Grinding Teeth: Yes___ No___
F. Do you wear a night guard over your teeth? Yes___ No___ If you have a night guard, is it? ___ Hard ___Soft
Is it worn on your ___ Upper ___ Lower

XV. ***Exercise***

A. Do you exercise? Yes___ No___
B. If YES then what type of exercise? _____
C. How many days per week do you exercise? _____
D. How long do you exercise each time (on average) _____?

XVI. *Family History*

Member	Deceased or Living	Age	Medical Problems
1. Father	_____	_____	_____
2. Mother	_____	_____	_____
3. Siblings	_____	_____	_____
4. Spouse	_____	_____	_____

Are you adopted? Yes___ No___

XVII. *Social History*

A. Relationship Status:

- ☐ Single
- ☐ Separated
- ☐ Significant Other
- ☐ Divorced
- ☐ Married
- ☐ Widowed

B. Highest Level of Education Completed:

- ☐ GED
- ☐ College
- ☐ High School
- ☐ Graduate
- ☐ Vocational
- ☐ Other _____

C. With whom do you live? Name: _____ Relationship: _____

D. What is your current employment?

☐ Employed Full Time ☐ Retired ☐ Employed Part Time ☐ Unemployed Due To Pain
☐ Self-employed ☐ Unemployed Due To Other Reason ☐ Homemaker
☐ How Long Have You Been Unemployed or Retired? _____

Are You On Disability? Yes___ No___
Date Disability started: ____
Reason for Disability: _____

E. Number of hours worked per week:_____ Are you happy with your job?____

XI. *Financial Information*

Do you have any legal action pending related to this pain or any other health issue? Yes___ No___ if yes please list:

Attorneys Name_____

Address _____Phone Number_____

XIX. *Psychological History*

1. Describe your mood: _____

_____

_____

2. Do you Have problems with the following:

☐ Concentration	☐ Anxiety	☐ Homicidal Thoughts
☐ Motivation	☐ Depression	☐ Appetite
☐ Sleep	☐ Self-Worth	☐ Suicidal Thoughts

3. Do you have a history of physical or mental abuse? Yes___ No___

4. Are you currently in therapy? Yes___ No___

5. If Yes, Name _____: Degree M. D. _____; Ph. D. _____; MFCC _____
Phone # (____) _____

6. If Yes, how often do you see the person in 5# above: _____