

HEAD, NECK AND FACIAL PAIN QUESTIONNAIRE

Form 401A

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

PATIENT INFORMATION

TODAY'S DATE _____

MR. MS. MISS MRS. DR. NAME _____
First Middle Initial Last

AGE: _____ BIRTH DATE: _____ MALE FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: Single Married Widowed Divorced Other

RESPONSIBLE PARTY: _____

FAMILY DENTIST _____

ADDRESS _____

FAMILY PHYSICIAN _____

ADDRESS _____

REFERRED BY: _____

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

1. Please **number** your complaints with #1 being the most severe symptom, #2 the next, etc.

2. Then rate your complaints for frequency and intensity:

Frequency:

(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

Intensity:

(0 is NO PAIN and 10 is MOST SEVERE PAIN)

<u>Number</u>	<u>Frequency</u>	<u>Intensity</u>
<i>#1 = the most severe symptom</i>	1-4	0-10
___ Back Pain	___	___
___ Dizziness	___	___
___ Ear Congestion	___	___
___ Ear Pain	___	___
___ Eye Pain	___	___
___ Facial pain	___	___
___ Fatigue	___	___
___ Headaches	___	___
___ Inability to open mouth	___	___
___ Jaw Clicking	___	___
___ Jaw Joint Noises	___	___
___ Jaw Locking	___	___
___ Jaw Pain	___	___
___ Limited Mouth Opening	___	___
___ Migraine Headaches	___	___
___ Muscle Twitching	___	___
___ Neck Pain	___	___
___ Pain when Chewing	___	___
___ Ringing in the Ears	___	___
___ Shoulder Pain	___	___
___ Sinus Congestion	___	___
___ Throat Pain	___	___
___ Visual Disturbances	___	___
___ <i>Other - write in:</i>	___	___
___	___	___
___	___	___

Patient Signature _____

Date _____

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

Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics	Y <input type="checkbox"/> N <input type="checkbox"/> Latex	Y <input type="checkbox"/> N <input type="checkbox"/> Sedatives
Y <input type="checkbox"/> N <input type="checkbox"/> Aspirin	Y <input type="checkbox"/> N <input type="checkbox"/> Local anesthetics	Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills
Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates	Y <input type="checkbox"/> N <input type="checkbox"/> Metals	Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs
Y <input type="checkbox"/> N <input type="checkbox"/> Codeine	Y <input type="checkbox"/> N <input type="checkbox"/> Penicillin	Y <input type="checkbox"/> N <input type="checkbox"/> Other _____
Y <input type="checkbox"/> N <input type="checkbox"/> Iodine	Y <input type="checkbox"/> N <input type="checkbox"/> Plastic	_____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics	Y <input type="checkbox"/> N <input type="checkbox"/> Cortisone	Y <input type="checkbox"/> N <input type="checkbox"/> Nerve pills
Y <input type="checkbox"/> N <input type="checkbox"/> Anticoagulants	Y <input type="checkbox"/> N <input type="checkbox"/> Diet pills	Y <input type="checkbox"/> N <input type="checkbox"/> Pain medication
Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates	Y <input type="checkbox"/> N <input type="checkbox"/> Heart medication	Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills
Y <input type="checkbox"/> N <input type="checkbox"/> Blood thinners	Y <input type="checkbox"/> N <input type="checkbox"/> Insulin	Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs
Y <input type="checkbox"/> N <input type="checkbox"/> Codeine	Y <input type="checkbox"/> N <input type="checkbox"/> Muscle relaxants	Y <input type="checkbox"/> N <input type="checkbox"/> Tranquilizers

Other _____

PLEASE LIST ANY TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

Practitioner	Specialty	Treatment & approximate date
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		

MEDICAL HISTORY (Please indicate dates on questions checked YES)

Y <input type="checkbox"/> N <input type="checkbox"/> Adenoids Removed	Y <input type="checkbox"/> N <input type="checkbox"/> Current pregnancy	Y <input type="checkbox"/> N <input type="checkbox"/> Glaucoma
Y <input type="checkbox"/> N <input type="checkbox"/> Tonsils Removed	Y <input type="checkbox"/> N <input type="checkbox"/> Depression	Y <input type="checkbox"/> N <input type="checkbox"/> Gout
Y <input type="checkbox"/> N <input type="checkbox"/> Anemia	Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/> Hay fever
Y <input type="checkbox"/> N <input type="checkbox"/> Arteriosclerosis	Y <input type="checkbox"/> N <input type="checkbox"/> Difficulty concentrating	Y <input type="checkbox"/> N <input type="checkbox"/> Hearing impairment
Y <input type="checkbox"/> N <input type="checkbox"/> Asthma	Y <input type="checkbox"/> N <input type="checkbox"/> Dizziness	Y <input type="checkbox"/> N <input type="checkbox"/> Heart murmur
Y <input type="checkbox"/> N <input type="checkbox"/> Autoimmune disorders	Y <input type="checkbox"/> N <input type="checkbox"/> Emphysema	Y <input type="checkbox"/> N <input type="checkbox"/> Heart disorder
Y <input type="checkbox"/> N <input type="checkbox"/> Bleeding easily	Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy	Y <input type="checkbox"/> N <input type="checkbox"/> Heart pacemaker
Y <input type="checkbox"/> N <input type="checkbox"/> Blood pressure <input type="checkbox"/> High <input type="checkbox"/> Low	Y <input type="checkbox"/> N <input type="checkbox"/> Excessive thirst	Y <input type="checkbox"/> N <input type="checkbox"/> Heart palpitations
Y <input type="checkbox"/> N <input type="checkbox"/> Bruising easily	Y <input type="checkbox"/> N <input type="checkbox"/> Fluid retention	Y <input type="checkbox"/> N <input type="checkbox"/> Heart valve replacement
Y <input type="checkbox"/> N <input type="checkbox"/> Cancer	Y <input type="checkbox"/> N <input type="checkbox"/> Frequent cough	Y <input type="checkbox"/> N <input type="checkbox"/> Hemophilia
Y <input type="checkbox"/> N <input type="checkbox"/> Chemotherapy	Y <input type="checkbox"/> N <input type="checkbox"/> Frequent illnesses	Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis
Y <input type="checkbox"/> N <input type="checkbox"/> Chronic fatigue	Y <input type="checkbox"/> N <input type="checkbox"/> Frequent stressful situations	Y <input type="checkbox"/> N <input type="checkbox"/> Hypoglycemia
Y <input type="checkbox"/> N <input type="checkbox"/> Cold hands & feet	Y <input type="checkbox"/> N <input type="checkbox"/> General anesthesia	

Patient Signature _____ Date _____

MEDICAL HISTORY CONTINUED

- Y N Immune system disorder
- Y N Injury to
 - Face Mouth
 - Neck Teeth
- Y N Insomnia
- Y N Intestinal disorders
- 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 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 Osteoporosis
- 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 Scarlet fever
- Y N Shortness of breath
- Y N Sinus problems
- Y N Skin disorder
- 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
 - Ear Infections
 - Sore Throats
- Y N Tired muscles
- Y N Tuberculosis
- Y N Tumors
- Y N Urinary disorders
- Y N Wisdom teeth (Third Molar) extraction

Other _____

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN	LOCATION	SEVERITY			FREQUENCY			DURATION				
		MILD	MODERATE		OCCASIONAL (MONTHLY OR LESS)	FREQUENT (WEEKLY)	CONSTANT (EVERY DAY)	SECONDS	MINUTES	HOURS	DAYS	WEEKS
				SEVERE								
L R B	Front of your head (Frontal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Entire head (Generalized)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Top of your head (Parietal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Back of your head (Occipital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	In your temples (Temporal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

JAW PAIN

- L R B Jaw pain - on opening
- L R B Jaw pain - while chewing
- L R B Jaw pain - at rest

EAR RELATED CONDITIONS

- Y N Buzzing in the ears
- Y N Ear congestion
- Y N Ear pain
- Y N Hearing loss
- Y N Pain behind the ear
- Y N Pain in front of the ear
- Y N Recurrent ear infections
- Y N Tinnitus (ringing in the ear)

JAW SYMPTOMS

- Y N Jaw clicks
- Y N Jaw locks closed
- Y N Jaw locks open
- Y N Jaw popping
- Y N Teeth clenching
- Y N Teeth grinding

THROAT NECK & BACK RELATED CONDITIONS

- Y N Back pain - lower
- Y N Back pain - middle
- Y N Back pain - upper
- Y N Chronic sore throat
- Y N Constant feeling of a foreign object in throat
- Y N Difficulty in swallowing
- Y N Limited movement of neck
- Y N Neck pain
- Y N Numbness in the hands or fingers

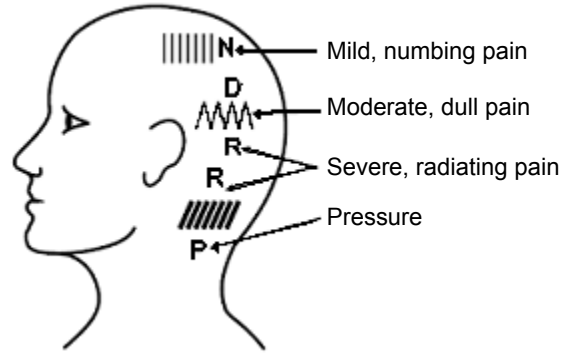
EYE RELATED CONDITIONS

- Y N Blurred vision
- Y N Double vision
- Y N Eye pain
- Y N Pain or pressure behind the eyes
- Y N Photophobia (extreme sensitivity to light)

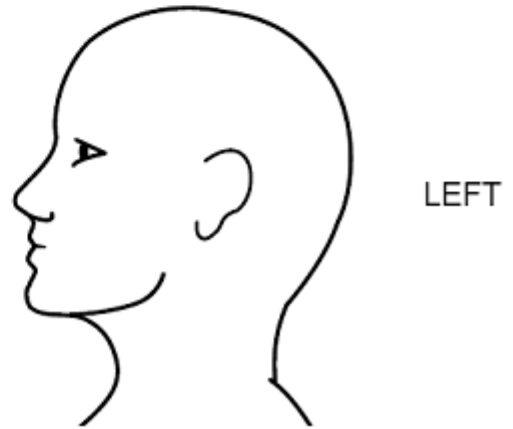
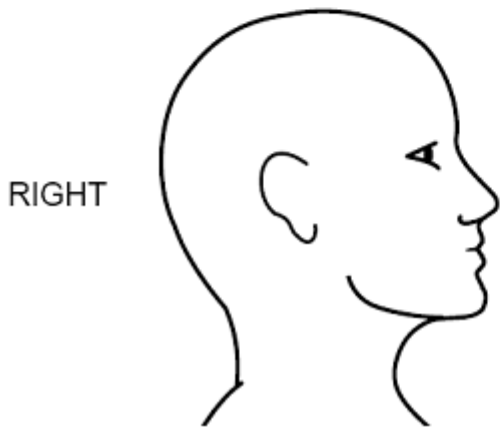
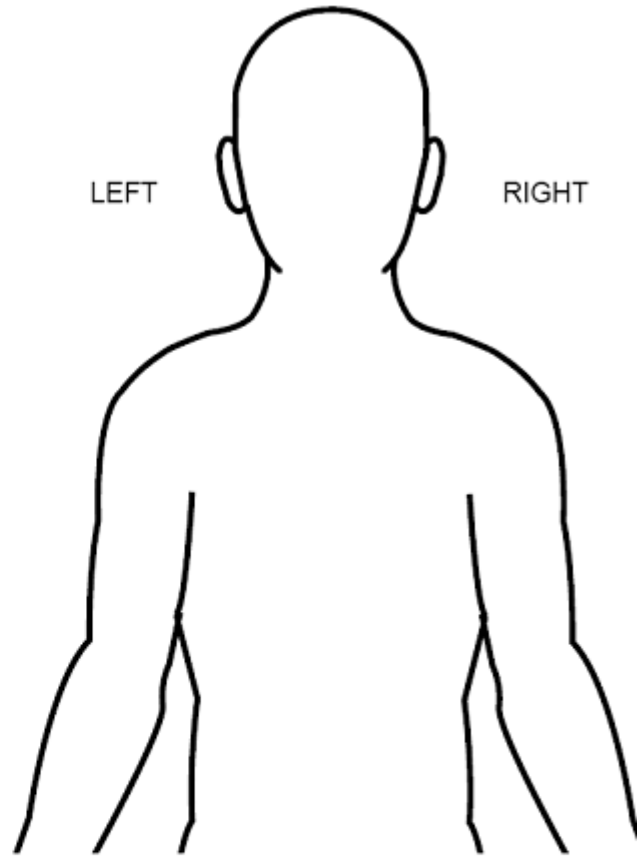
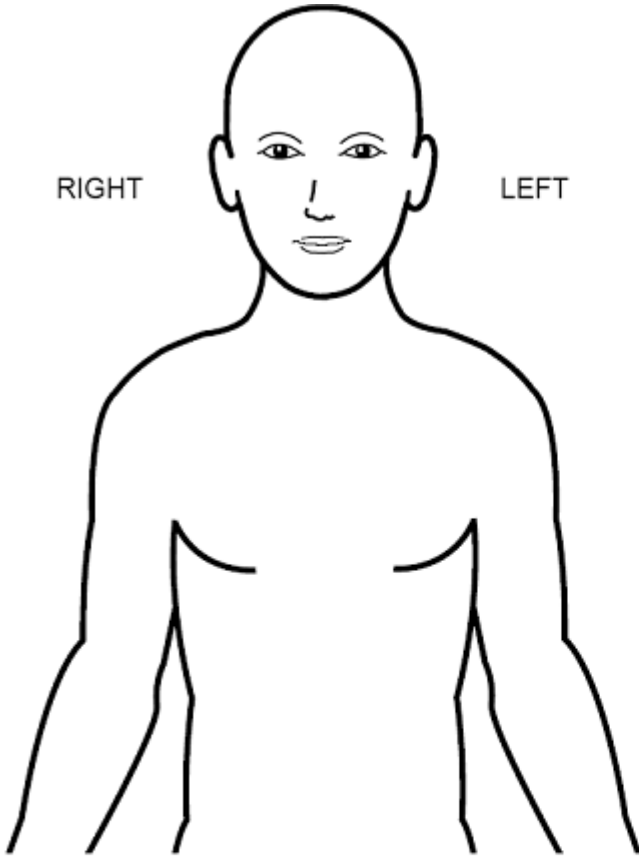
Patient Signature _____ Date _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

EXAMPLE



- | | | |
|---------------|--|-------------|
| MILD PAIN | | B Burning |
| | | D Dull |
| | | N Numbing |
| MODERATE PAIN | | P Pressure |
| | | S Sharp |
| | | T Tingling |
| SEVERE PAIN | | R Radiating |



Patient Signature _____

Date _____

HISTORY OF ACCIDENT

IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT, COMPLETE THIS SECTION.

DATE OF ACCIDENT OR INCIDENT _____

WERE YOU ?

- (Choose one)
- A passenger in a vehicle
 - The driver of a vehicle
 - A pedestrian
 - At work

AND...

- (Choose one)
- Did you fall?
 - Were you hit by an object?
 - Did you hit an object?
 - Other _____

IF IN A VEHICLE WHERE WAS THE VEHICLE HIT?

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

INDICATE IF THERE WAS ANY DIRECT TRAUMA.

DID YOUR

- Forehead
- Face
- Chin
- Side of head
- Back of head
- Top of head
- Teeth
- Jaw
- Other _____

FORCIBLY STRIKE

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

WERE ANY AREAS OF YOUR BODY PAINFUL SHORTLY AFTER THE ACCIDENT/INCIDENT?

- Head
- Neck
- Face
- Jaw
- Left shoulder
- Right shoulder
- Left arm
- Right arm
- Lower back
- Upper back
- Other: _____

BRIEFLY DESCRIBE THE HISTORY OF SYMPTOMS, ACCIDENT OR INCIDENT: _____

DID YOU GO TO THE HOSPITAL? Yes No By Car By Ambulance

TAKEN TO THE HOSPITAL FOR X-RAYS & EVALUATION

WERE YOU SUBSEQUENTLY RELEASED ON (Date) _____

WHICH HOSPITAL? _____

HAD A DOCTOR OR DENTIST EVER DIAGNOSED A TMJ DISORDER PRIOR TO THE ACCIDENT?

Yes No If yes, please explain _____

Patient Signature _____ Date _____

IF YOU HAD A PREVIOUS ACCIDENT, PLEASE GIVE AN ACCURATE DESCRIPTION, _____

_____ INCLUDING DATE: _____

NAMES AND ADDRESSES OF HOSPITALS AND DOCTORS WHERE TREATED FOR THIS PREVIOUS ACCIDENT: _____

IF YOU HAVE MISSED ANY WORK PLEASE GIVE DATES: _____

INSURANCE INFORMATION

AUTO INSURANCE

Please mark each insurance category

your insurance driver of vehicle's insurance other vehicle's insurance owner of vehicle's insurance

Insured _____ Insured's Soc. Sec. No. _____

Relationship _____

Insured's Address _____

City, State, Zip _____

Insurance Co. _____ Adjuster (not agent) _____ Phone No. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No. _____ Claim No. _____ Has this been reported? Yes No

OTHER TYPES OF INSURANCE

HEALTH INSURANCE (Complete even if you are covered by auto insurance)

Insured _____ Insured's Soc. Sec. No. _____

Relationship _____

Insured's Address _____

City, State, Zip _____

Insurance Co. _____ Adjuster (not agent) _____ Phone No. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No. _____ Group No. _____ I.D. No. _____

WORKER'S COMPENSATION

Employee _____

Address _____

City, State, Zip _____

Employer _____ Phone No. _____ Supervisor _____

Has this been reported? Yes No If yes, was treatment authorized? _____

Insurance Co. _____

Insurance Billing Address _____

City, State, Zip _____

Policy No. _____ Group No. _____ I.D. No. _____

If you have additional insurance, please enter the information on the reverse side of this form.

Patient Signature _____ Date _____

ATTORNEY INFORMATION

If you have an attorney representing you, please complete the following:

Attorney's Name _____ Paralegal _____ Phone No. _____

Address _____

City, State, Zip _____

Are you involved in a lawsuit regarding your condition? Yes No

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

FOR OFFICE USE ONLY

Insurance Company _____

Group Health Auto Government Self Insured Dental

Contact Person _____

Effective date of this policy, _____ TMJ policy exclusions _____

Amount of deductible? _____ Has it been satisfied? _____

At what percentage are benefits paid? _____

Is there a policy maximum for TMJ disorders? _____

Is precertification required _____

Can benefits be assigned to doctor? Yes No

What information is needed to process the claim? _____

For No Fault: Amount of benefits _____

Mailing Address _____

City, State, Zip _____

Adjuster _____ Assignment approved Yes No

By _____

Other: _____

Patient Signature _____ Date _____

WESTFIELD ORAL SURGERY ASSOCIATES
320 Lenox Avenue · Westfield, New Jersey 07090

FINANCIAL AGREEMENT

Please read the following and sign in the appropriate locations. If you have any questions whatsoever with regard to this agreement, please inquire at the front desk.

A. I _____, the undersigned, have insurance with _____ (insurance company,) and assign directly to Dr. Philip R. Geron or Westfield Oral Surgery Associates, all benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. Deductibles or co-payments, if applicable, must be made at time of service.

Signature _____ Date _____

B. **Financial Agreement.** I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance plans. Estimated fees for service will be provided upon request after examination. If for some unusual reason, payment cannot be made in full at the time of service, any fees still not paid within 30 days of service will be billed at 1.5 percent monthly interest, and all legal/collection costs will be the patient's/guardian's responsibility.

Signature _____ Date _____

C. **Minor/Child Consent.** I, _____ (parent/guardian), being the parent of _____ (child's name), do hereby request and authorize the staff to perform necessary services for my child, including, but not limited to, examination, X-rays, administration of appropriate anesthetics, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature _____ Date _____

If alternate financial agreement has been made, this will be documented on this financial agreement plan, as noted above.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)