Headache, Neckache and Facial Pain Diagnosis

Name _____ Today's Date _____

Address _____ Date of birth _____ _____Male _____Female

_____ __Married __Separated __Divorced __Widowed __Single

Home telephone _____ Occupation _____
(area code)

Business telephone _____ Family Physician _____
(area code)

Referred to this office by _____ Family Dentist _____

INSTRUCTIONS: Please answer all the questions as accurately, as honestly, and in as much detail as possible. The accuracy and completeness of your answers directly affect the diagnostic decisions made on your behalf. Although some questions may seem "strange" or not applicable to you, there is a specific reason behind each question asked. Your confidentiality will be respected. Please give this your "best effort".

1. **Medicines:** Mark an X in the box next to any medicines that you are now taking, or that you are sensitive or allergic to:

Now Taking	Sensitive or Allergic to:		Specific Name of Prescription or Brand Name
☐	☐	Antibiotics	
☐	☐	Sulfa	
☐	☐	Tetracycline	
☐	☐	Penicillin	
☐	☐	Sedatives	
☐	☐	Barbituates	
☐	☐	Sleeping Pills	
☐	☐	Muscle relaxants (Valium, etc.)	
☐	☐	Stimulants (Caffeine, no-Doz, etc.)	
☐	☐	Thyroid	
☐	☐	Insulin	
☐	☐	Blood Pressure Pills	
☐	☐	Diuretics (water pills)	
☐	☐	Heart Pills (Digitalis, etc.)	
☐	☐	Nerve Pills	
☐	☐	Pain Pills (Demerol, Codiene, etc.)	
☐	☐	Cortizone	
☐	☐	Diet Pills	

PLEASE *SIGN EACH PAGE*

Signature: _____

Date: _____

CONTINUE TO NEXT PAGE

1. Medicines (continued)

Now Taking	Sensitive or Allergic To:		
☐	☐	Aspirin or Aspirin Substitutes	_____
☐	☐	Antacids	_____
☐	☐	Laxatives	_____
☐	☐	Cold Tablets	_____
☐	☐	Allergy Medication	_____
☐	☐	Sinus Medication	_____
☐	☐	Birth Contol Pills	_____
☐	☐	Any other medications	_____

2. Food Allergies: Mark an X in the appropriate box indicating if you have an allergic response to any of the following foods:

Yes	No	
☐	☐	Chinese Food
☐	☐	Italian Food
☐	☐	Soy Sauce
☐	☐	Milk (or other diary products) _____
☐	☐	Cheese (particularly cheese with molds on them) _____
☐	☐	Brewed Coffee
☐	☐	De-caffeinated Coffee
☐	☐	Sugar
☐	☐	Beer
☐	☐	Wine(s)
☐	☐	Alcohol
☐	☐	Red Meats
☐	☐	Seafood
☐	☐	Fast Foods (McDonald's etc.)
☐	☐	Tabasco Sauce
☐	☐	Hot Dogs
☐	☐	Cold Cuts
☐	☐	Other: _____

Signature: _____
Date: _____

CONTINUE TO NEXT PAGE

3. Tests and Immunizations: Mark an X next to those that you have had. Enter the year of the most recent test(s) and immunization(s).

TESTS	IMMUNIZATIONS (Please Specify)
☐ 19____ brain scan	☐ 19____ _____
☐ 19____ electrocardiogram	☐ 19____ _____
☐ 19____ TB test	☐ 19____ _____
☐ 19____ other x-rays	☐ 19____ _____
☐ 19____ _____	☐ 19____ _____
☐ 19____ _____	☐ 19____ _____
☐ 19____ _____	☐ 19____ _____

4. Medical History: Mark an X in the appropriate box indicating whether you have had, or now have, any of the following conditions or symptoms:

Have Never Had	Have Had	Now Have	
☐	☐	☐	Arteriosclerosis
☐	☐	☐	Stroke
☐	☐	☐	Rheumatoid arthritis
☐	☐	☐	Swollen, stiff or painful joints
☐	☐	☐	Osteoarthritis (neck, joints, etc.)
☐	☐	☐	Cortizone therapy
☐	☐	☐	Heart trouble
☐	☐	☐	Heart murmer
☐	☐	☐	Pains or tightness in chest
☐	☐	☐	Fast pulse, heart palpations, thumping or racing heart
☐	☐	☐	Low Blood Pressure (hypotension)
☐	☐	☐	High Blood Pressure (hypertension)
☐	☐	☐	Frequent nose bleeds for no reason at all
☐	☐	☐	Poor circulation
☐	☐	☐	Fainting spells or feeling faint
☐	☐	☐	Leg cramps at night or when walking
☐	☐	☐	Swollen ankles or feet
☐	☐	☐	Hands get cold
☐	☐	☐	Implanted Pacemaker

Signature: _____

Date: _____

CONTINUE TO NEXT PAGE

4. Medical History (continued)

Never Had	Had	Now Have	
☐	☐	☐	Feet get cold
☐	☐	☐	Tendency to be too hot or cold
☐	☐	☐	Bruise easily
☐	☐	☐	Bleed easily from cuts
☐	☐	☐	Slow healing sores
☐	☐	☐	Muscle soreness or stiffness
☐	☐	☐	Muscle tremors
☐	☐	☐	Hand tremors
☐	☐	☐	Diabetes
☐	☐	☐	More thirsty than usual lately
☐	☐	☐	High or low blood sugar
☐	☐	☐	Sugar in urine
☐	☐	☐	Blood in urine
☐	☐	☐	Asthma
☐	☐	☐	Shortness of breath
☐	☐	☐	Use extra pillows to help breathing at night
☐	☐	☐	Chronic coughing up phlegm (thick spit)
☐	☐	☐	Frequent colds
☐	☐	☐	Psychological or psychiatric care
☐	☐	☐	Nervous breakdown
☐	☐	☐	Hard to concentrate or remember
☐	☐	☐	Feel exhausted or fatigued most of the time
☐	☐	☐	Difficulty falling asleep or staying asleep
☐	☐	☐	Lose temper easily
☐	☐	☐	Frequently irritable
☐	☐	☐	Ulcers, heartburn or digestive problems
☐	☐	☐	Skin problems, rashes, psoriasis, etc.
☐	☐	☐	Fits, convulsions or epilepsy
☐	☐	☐	Schizophrenia
☐	☐	☐	Cerebral Palsy
☐	☐	☐	Parkinson's disease
☐	☐	☐	Multiple sclerosis
☐	☐	☐	Handwriting changed recently

Signature: _____

Date: _____

CONTINUE TO NEXT PAGE

4. Medical History (continued)

Have Never Had	Have Had	Now Have	
☐	☐	☐	Liver disorders, hepatitis, etc.
☐	☐	☐	Heavy metal problems
☐	☐	☐	Mononucleosis
☐	☐	☐	Endocrine or hormone problems
☐	☐	☐	Birth control pills
☐	☐	☐	Pregnancy
☐	☐	☐	Venereal disease
☐	☐	☐	Cancer
☐	☐	☐	Drug addiction
☐	☐	☐	Alcohol addiction

5. Head, Neck and Face Symptoms: Mark X in the appropriate box indicating whether you have had, or now have, any of the following conditions or symptoms, and whether it occurred on the left or right side or both:

Have Never Had	Have Had	Now Have		Left	Right
☐	☐	☐	Accident or trauma to head, face or neck	☐	☐
☐	☐	☐	Headaches at crown of head	☐	☐
☐	☐	☐	Headaches in forehead (above eyebrows)	☐	☐
☐	☐	☐	Headaches in left or right temple	☐	☐
☐	☐	☐	Headaches in back of head	☐	☐
☐	☐	☐	Itching in, around, or behind eyes	☐	☐
☐	☐	☐	Pain in, around, or behind eyes	☐	☐
☐	☐	☐	Eyelid tics	☐	☐
☐	☐	☐	Eyes blink or water most of the time	☐	☐
☐	☐	☐	Eyesight blurs	☐	☐
☐	☐	☐	Eyesight getting worse	☐	☐
☐	☐	☐	Allergies	☐	☐
☐	☐	☐	Sinus problems	☐	☐
☐	☐	☐	Nose stuffed when you don't have a cold	☐	☐
☐	☐	☐	Nose runs when you don't have a cold	☐	☐
☐	☐	☐	Snore	☐	☐
☐	☐	☐	Dizziness or lightheadedness	☐	☐
☐	☐	☐	Motion sickness (car, airplane, boat, etc.)	☐	☐

Signature: _____

Date: _____

CONTINUE TO NEXT PAGE

5. Head, Neck and Face Symptoms (continued)

Have Never Had	Have Had	Now Have		Left	Right
☐	☐	☐	Easily nauseated (feel like vomiting)	☐	☐
☐	☐	☐	Itchiness or stuffiness in ears	☐	☐
☐	☐	☐	Running ears	☐	☐
☐	☐	☐	Excessive ear wax formed	☐	☐
☐	☐	☐	Ringing, hissing or buzzing sounds in ears	☐	☐
☐	☐	☐	Grating noise in ears (like sand particles)	☐	☐
☐	☐	☐	Earaches or ear pain	☐	☐
☐	☐	☐	Hearing Loss	☐	☐
☐	☐	☐	Accident to teeth	☐	☐
☐	☐	☐	Broken jaw	☐	☐
☐	☐	☐	Mouth breather	☐	☐
☐	☐	☐	Can't open mouth all the way	☐	☐
☐	☐	☐	Mouth goes to one side when fully opened	☐	☐
☐	☐	☐	Clench teeth during day	☐	☐
☐	☐	☐	Grind teeth during night	☐	☐
☐	☐	☐	Difficult or painful to swallow (food, pills, fluid)	☐	☐
☐	☐	☐	Generally sore mouth	☐	☐
☐	☐	☐	Dry mouth (not enough saliva)	☐	☐
☐	☐	☐	Painful or burning tongue	☐	☐
☐	☐	☐	Painful or sore teeth	☐	☐
☐	☐	☐	Teeth sensitive to hot or cold	☐	☐
☐	☐	☐	Dental infections or abcessed teeth	☐	☐
☐	☐	☐	Gum disease or bleeding gums	☐	☐
☐	☐	☐	Taste sensations changed lately	☐	☐
☐	☐	☐	Metal taste in mouth	☐	☐
☐	☐	☐	Oral Surgery	☐	☐
☐	☐	☐	Wisdom teeth extracted	☐	☐
☐	☐	☐	General Anesthesia	☐	☐
☐	☐	☐	Caps or crowns on teeth	☐	☐
☐	☐	☐	Dental bridgework	☐	☐
☐	☐	☐	Teeth ground on by Dentist	☐	☐
☐	☐	☐	Orthodontia (braces)	☐	☐
☐	☐	☐	Chew gum	☐	☐

Signature: _____

Date: _____

CONTINUE TO NEXT PAGE

5. Head, Neck and Face Symptoms (continued)

Have Never Had	Have Had	Now Have		Left	Right
☐	☐	☐	Chew tobacco	☐	☐
☐	☐	☐	Neck injury or operation	☐	☐
☐	☐	☐	Twisting neck quickly makes noise	☐	☐
☐	☐	☐	Twisting neck quickly causes pain	☐	☐
☐	☐	☐	Lumps or swelling in neck	☐	☐
☐	☐	☐	Chronic stiff neck	☐	☐
☐	☐	☐	Neckaches	☐	☐
☐	☐	☐	Whiplash neck injury	☐	☐
☐	☐	☐	Cervical traction neck collar	☐	☐
☐	☐	☐	Chronic dry cough	☐	☐
☐	☐	☐	Throat hoarse when you don't have a cold	☐	☐
☐	☐	☐	Throat sore when you don't have a cold	☐	☐
☐	☐	☐	Chronic feeling of foreign object (chicken bone) in throat	☐	☐
☐	☐	☐	Numbness of shoulder, arms, hands, fingers	☐	☐
☐	☐	☐	Shoulder Pain	☐	☐
☐	☐	☐	Scoliosis (curvature of the spine)	☐	☐
☐	☐	☐	Backaches	☐	☐
☐	☐	☐	Unequal leg length	☐	☐
☐	☐	☐	Inability to sit still for prolonged time	☐	☐

6. When did you first experience the pain for which you are now seeking help? Date:_____

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

8. Under what circumstances did the pain begin? (Please check all that apply)

- ☐ Accident at work
- ☐ Accident at home
- ☐ Other accident
- ☐ At work, but not an accident
- ☐ Following surgery
- ☐ Following illness
- ☐ Pain just began, can't relate it to anything
- ☐ Other Reasons Or Circumstances (Please Explain)_____

9. What are your specific complaints? From what symptoms do you most desire relief? List from most important to least important.

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Signature:_____
Date:_____

CONTINUE TO NEXT PAGE

10. Practitioners: Since your pain condition began, which of the following people have you seen for treatment and pain relief?

Have Seen	Now Seeing		Have Seen	Now Seeing	
☐	☐	Acupuncturist	☐	☐	Neurologist (Nervous System)
☐	☐	Allergist	☐	☐	Neurosurgeon
☐	☐	Anesthesiologist	☐	☐	Nutritionist
☐	☐	Cardiologist (Heart)	☐	☐	Opthalmologist (Eyes)
☐	☐	Chiropractor	☐	☐	Optometrist
☐	☐	Clergyman	☐	☐	Orthopedist (Bones, Joints)
☐	☐	Dentist	☐	☐	Osteopathic Physician
☐	☐	Dermatologist (Skin)	☐	☐	Pediatrician (Children)
☐	☐	Ear, Nose, or Throat	☐	☐	Plastic Surgeon
☐	☐	Endocrinologist	☐	☐	Proctologist
☐	☐	Faith Healer	☐	☐	Psychiatrist
☐	☐	General and/or Family Practice Physician	☐	☐	Psychologist
			☐	☐	Radiologist
☐	☐	Gynecologist/Obstetrician	☐	☐	Surgeon (General)
☐	☐	Hypnotist	☐	☐	Other (Specify)
☐	☐	Internal Medicine (Internist)	_____		
☐	☐	Naturopath			

11. How long have you been bothered by this problem?

(a) _____ years (b) _____ months (c) _____ weeks

Headaches per week _____. Neckaches per week _____.

12. Are your symptoms worse:

Yes	No		Yes	No	
☐	☐	Upon arising in the morning	☐	☐	When with your parents
☐	☐	At work	☐	☐	When with your in-laws
☐	☐	At the end of your work day	☐	☐	When yawning
☐	☐	At school	☐	☐	In the Fall or Winter
☐	☐	At home	☐	☐	Hay Fever Season
☐	☐	When with your children	☐	☐	Rainy Weather

Signature:_____

Date:_____

CONTINUE TO NEXT PAGE

13. **Does any other member of your family have the same or similar problem?** Yes____ No____ If yes, explain

_____

_____

14. (a) **How many times have you been operated on for the pain?**

____zero ____one ____two ____three ____four ____five ____six or more times

(b) **Did the operation(s) bring relief from pain?**

____Yes ____No

15. (a) **How many times have you had nerve blocks (injections) for the pain?**

____zero ____one ____two ____three ____four ____five ____six or more times

(b) **Did any of these injections bring relief from the pain?**

____Yes ____No

16. **How often do you take medicine for relief of the pain?**

____Never ____Very Seldom ____Fairly Often ____Very Often ____Regularly

17. **What do you do that starts the pain, or makes it worse?** _____

_____

_____

18. **What activity or medicine decreases the pain or brings relief?**_____

_____

19. **Do you have days when the pain is so bad that you spend the day in bed?** Yes____ No____

_____

20. **Personal History:** Mark an X in the appropriate box indicating that you:

Yes	No	
☐	☐	Drink 6 or more cups of coffee or tea per day?
☐	☐	Drink 2 or more alcoholic drinks per day?
☐	☐	Smoke tobacco?
☐	☐	Use Marijuana?
☐	☐	Have trouble stopping the bleeding from even a small cut?
☐	☐	Are handicapped in any way?
☐	☐	Considered committing suicide?
☐	☐	Use, or have used heroin, cocaine, LSD, uppers, downers, or similar drugs?
☐	☐	Been told by some Doctors that your pain was imaginary or "all in your head"?
☐	☐	Have had Doctors or nurses act as if you were faking the pain?
☐	☐	Are bringing suit or expect to sue because of your pain?

Signature:_____

Date:_____

CONTINUE TO NEXT PAGE

21. Please describe any other pertinent information, symptom, disorder, etc., not previously covered.

22. What one vital piece of information are you holding back?

23. List the treatments you have had for this problem:

Doctor	Treatment

Signature: _____

Date: _____

CONTINUE TO NEXT PAGE

PLEASE READ THESE INSTRUCTIONS VERY CAREFULLY. WE WANT YOU TO INDICATE ON THE DRAWINGS ON THE NEXT PAGE EXACTLY WHERE YOUR PAIN IS, AND HOW MUCH PAIN YOU FEEL. READ ALL INSTRUCTIONS BEFORE YOU DO ANYTHING.

1. Mark on the drawing the exact spot(s) where your pain starts a solid dot (•). If the pain starts at that spot and radiates elsewhere (travels to another part of your face, head or neck), draw a line of arrows from the spot where it starts to where it ends. If it is a whole area that hurts, shade in that area with a pencil.

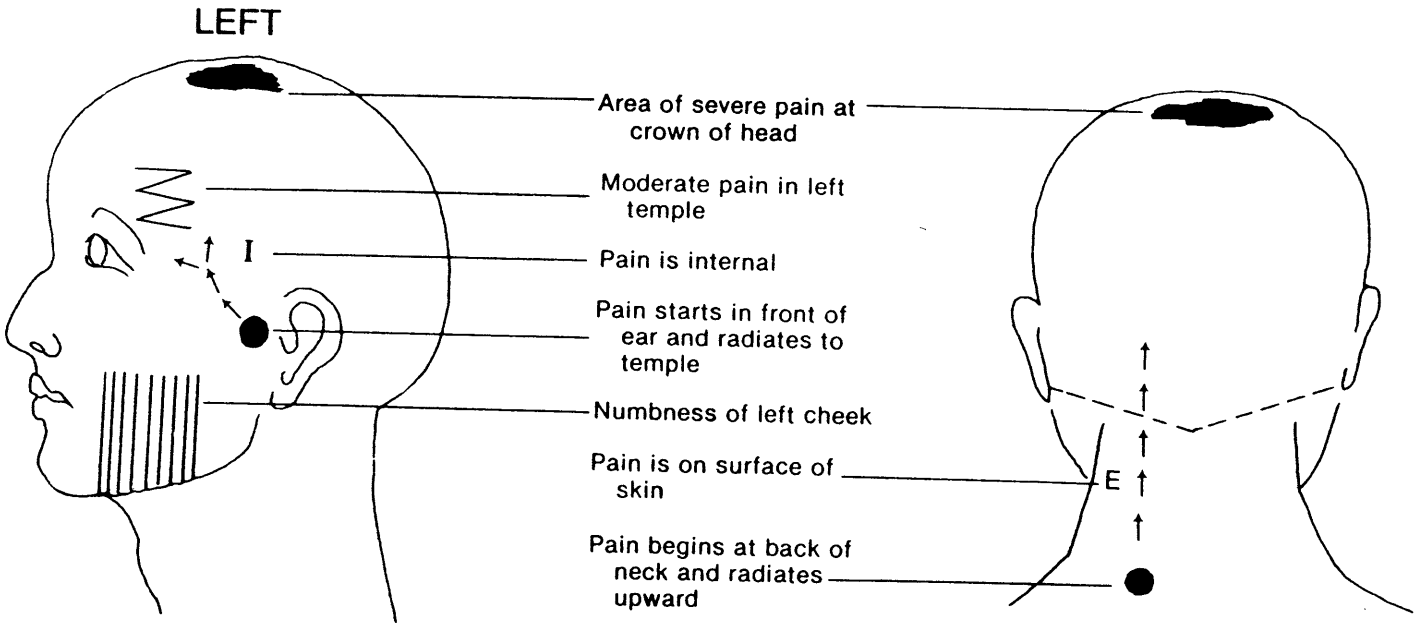
2. Next to the places on the drawing where you showed pain, put an "E" if the pain is external (skin surface); if the pain is internal (inside the body) mark this with an "I". If the pain is both internal and external, mark "EI".

3. After you have shown where the pain is, and where it travels to, we want to know how much pain you feel. Mark the painful area with the following symbols:

•	PAIN
E	EXTERNAL PAIN
I	INTERNAL PAIN
≷	MODERATE PAIN
▬	SEVERE PAIN
↑	SHOOTING PAIN
IIII	NUMBNESS

Before you begin to do anything to the drawings on the next page, look at the example and read the description of what it means so that you will understand perfectly what you are to do.

SAMPLE OF HOW TO INDICATE PAIN



Signature:_____

Date: _____

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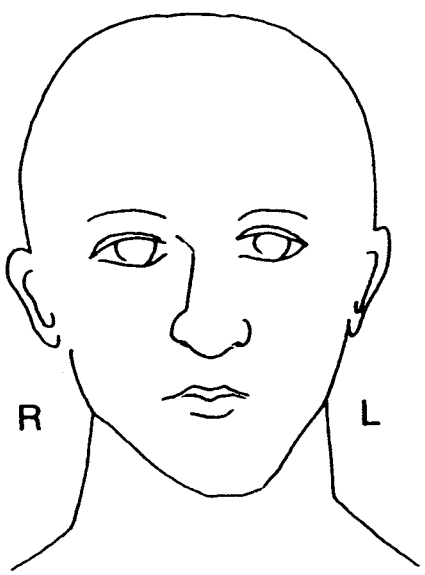
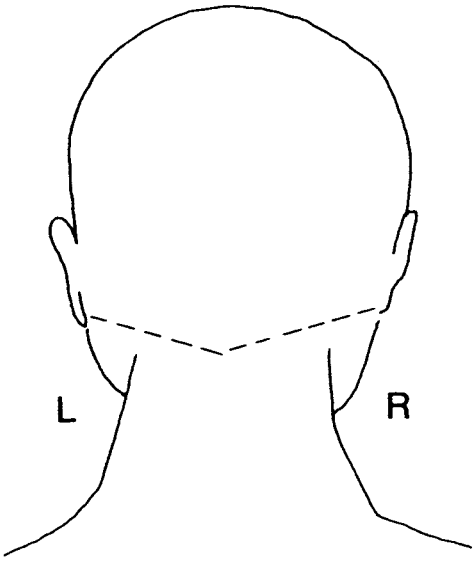
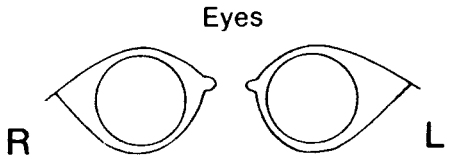




• PAIN
E EXTERNAL PAIN
I INTERNAL PAIN
MODERATE PAIN
SEVERE PAIN
SHOOTING PAIN
IIII NUMBNESS



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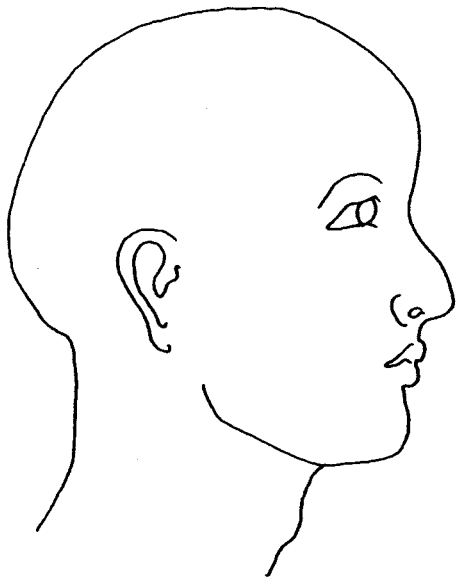

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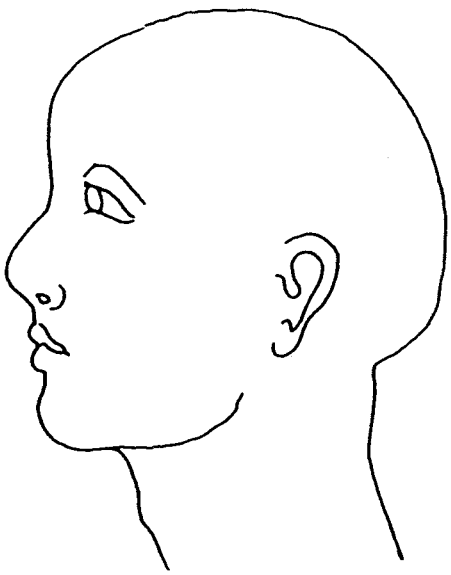

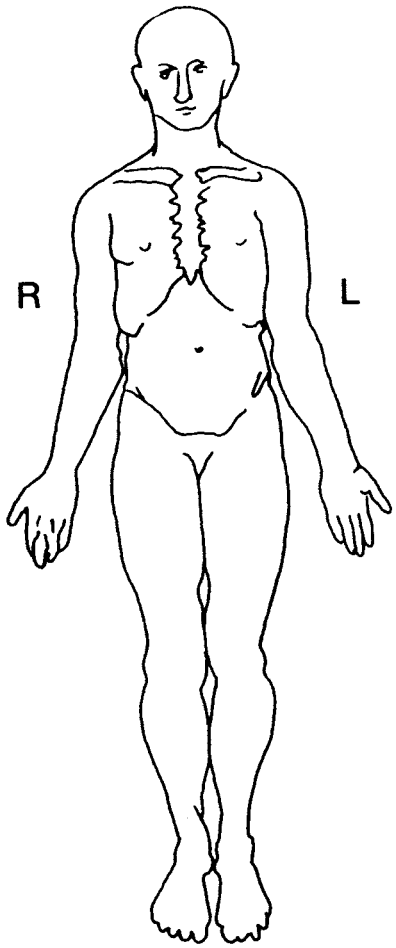

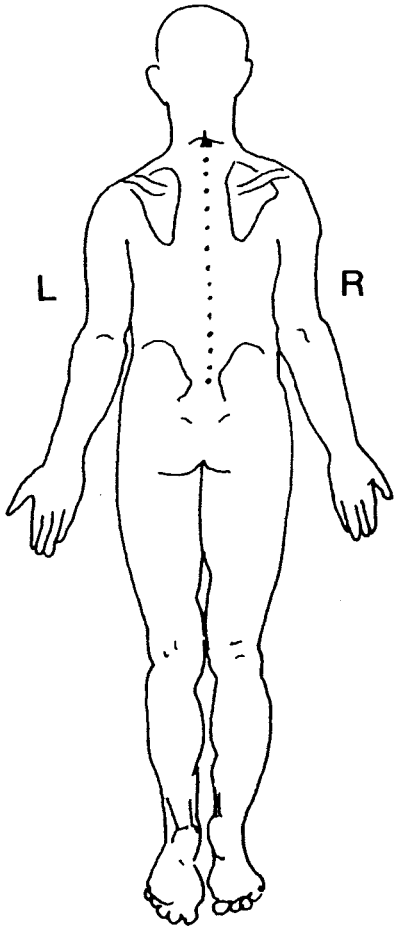

PLEASE BE SURE THAT YOU HAVE SIGNED EACH PAGE

Signature: _____

Date: _____