

1. Briefly describe your current pain problem. Why exactly are you seeking care?

2. Circumstances under which your pain problem (s) began:

- | | |
|---------------------------|------------------------------|
| a. ____ accident at work | e. ____ following surgery |
| b. ____ accident at home | f. ____ at work(no accident) |
| c. ____ other accident | g. ____ at home(no accident) |
| d. ____ following illness | i. ____ no known cause |
| h. ____ other | |

3. Briefly describe circumstances checked:

4. What does your pain feel like? Some of the words below describe your present pain. Circle only those words that describe it. Leave out any category that is not suitable. Use only a single word in each appropriate category (the one that best applies).

- | | | | | |
|---|-----------------------------------|---|----------------------------------|---|
| 1 Flickering
Quivering
Pulsing
Throbbing | 2 Jumping
Flashing
Shooting | 3 Pricking
Boring
Drilling
Stabbing
Lancinating | 4 Sharp
Cutting
Lacerating | 5 Pinching
Pressing
Gnawing
Cramping
Crushing |
|---|-----------------------------------|---|----------------------------------|---|

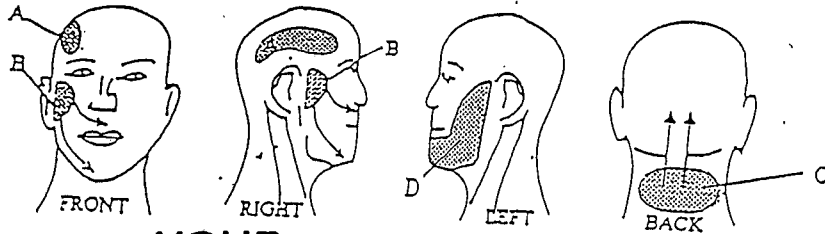
- | | | | | |
|--|--|---|---|------------------------------|
| 6 Tugging
Pulling
Wrenching
Searing | 7 Hot
Burning
Scalding
Stinging | 8 Tingling
Itchy
Smarting
Aching | 9 Dull
Sore
Hurting
Splitting
Heavy | 10 Tender
Taut
Rasping |
|--|--|---|---|------------------------------|

- | | | | | |
|-------------------------|-----------------------------|--|-----------------------------------|-------------------------|
| 11 Tiring
Exhausting | 12 Sickening
Suffocating | 13 Fearful
Frightful
Terrifying
Vicious | 14 Punishing
Grueling
Cruel | 15 Wretched
Blinding |
|-------------------------|-----------------------------|--|-----------------------------------|-------------------------|

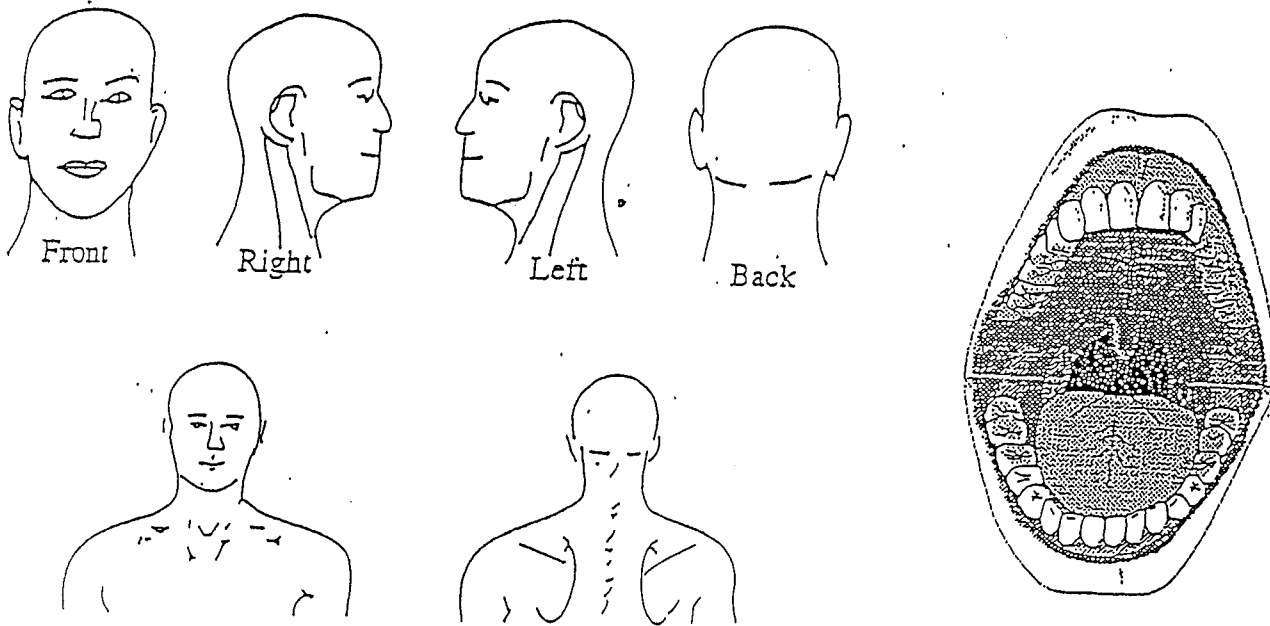
- | | | | | |
|--|--|---|-----------------------------|--|
| 16 Annoying
Troublesome
Miserable
Intense
Unbearable | 17 Spreading
Radiating
Penetrating
Piercing | 18 Tight
Numb
Drawn
Squeezing
Tearing | 19 Cool
Cold
Freezing | 20 Nagging
Nauseating
Agonizing
Dreadful
Torturing |
|--|--|---|-----------------------------|--|

5. On the diagrams, following the example below, mark the areas where you experience pain most frequently by shading, sketching, or outlining the painful areas in order of severity, with (A) being the most severe or distressing. If the pain frequently moves, mark the starting point (worst area) with an (X) and draw an arrow to where the pain moves.

PLEASE DO NOT USE THIS EXAMPLE TO DRAW YOUR PAIN AREAS



Mark or draw **YOUR** area(s) of pain on the diagrams with a sharp pencil:



6. How long have you had these pain complaints? (Approximate date of original onset):

A. _____ B. _____ C. _____ D. _____

Has your pain increased, decreased, or remained the same since it began? (circle one)

Increased

Decreased

Remained the same

Comments:

7. Each of the following questions is about your experience of pain. These questions can be answered by circling a word or words. If you wish to describe more than one head/face pain problem, list them individually in the area below (problems A, B, C, etc), listing your worst pain first. These are called your *CHIEF COMPLAINT(S): The problems for which you are seeking care here.

PROBLEM A _____

Intensity	Type of Pain	Frequency	Duration	Worst time of Day
Mild Moderate Severe	Sharp Dull Burning Aching Shooting Tingling Other _____	___times/day ___times/week ___times/month	Seconds Minutes Hours Days Constant Variable	Morning Afternoon Night Variable While eating, talking As day progresses

PROBLEM B _____

Intensity	Type of Pain	Frequency	Duration	Worst time of Day
Mild Moderate Severe	Sharp Dull Burning Aching Shooting Tingling Other _____	___times/day ___times/week ___times/month	Seconds Minutes Hours Days Constant Variable	Morning Afternoon Night Variable While eating, talking As day progresses

PROBLEM C _____

Intensity	Type of Pain	Frequency	Duration	Worst time of Day
Mild Moderate Severe	Sharp Dull Burning Aching Shooting Tingling Other _____	___times/day ___times/week ___times/month	Seconds Minutes Hours Days Constant Variable	Morning Afternoon Night Variable While eating, talking As day progresses

PROBLEM D _____

Intensity	Type of Pain	Frequency	Duration	Worst time of Day
Mild Moderate Severe	Sharp Dull Burning Aching Shooting Tingling Other _____	___times/day ___times/week ___times/month	Seconds Minutes Hours Days Constant Variable	Morning Afternoon Night Variable While eating, talking As day progresses

8. The following lines represent pain, to the most intense pain imaginable. Draw a mark on the line to best describe the intensity of your pain. (See example)

Example: If you have pain that is on average midway between no pain at all and the most severe pain you have ever experienced, then you should place a vertical mark midway on the line.

no pain _____ most pain ever

PLEASE COMPLETE THE FOLLOWING AS SHOWN IN THE EXAMPLE ABOVE:

- a. Your average pain level:
no pain _____ most pain ever
- b. Your pain at its worst:
no pain _____ most pain ever
- c. Your pain at its least:
No pain _____ most pain ever
- d. The following line represents pain on chewing. Mark the line depicting your pain level:
no pain on chewing _____ can't chew

9. Does your pain increase when you open wide? Yes No
Where?

10. If your pain is not constant, what events are most likely to make it start (what brings it on)?

PROBLEM A _____

PROBLEM B _____

PROBLEM C _____

PROBLEM D _____

11. What is most likely to make your general pain worse? (EXAMPLES: chewing, stress, sleep, talking, opening mouth wide, certain foods, weather, hot/cold food or drinks, exercise, lack of sleep, emotional upset, other...)

LIST IN ORDER OF SEVERITY (WORST FIRST)

PROBLEM A _____

PROBLEM B _____

PROBLEM C _____

PROBLEM D _____

12. What eases your general pain, or makes it better? (EXAMPLES: medication, sleep, vacation, massage, exercise, hot or cold compresses, relaxation, moving or holding jaw in a certain position)

List in order of effectiveness (most effective first)

PROBLEM A _____
 PROBLEM B _____
 PROBLEM C _____
 PROBLEM D _____

13. Is there anything that can make your pain go away?

14. How long on average can you go without pain, if at all?

15. Describe your longest period of complete relief.

16. Does anything occur or do you notice anything else when the pain is severe? For example, visual disturbances, nausea, perspiration, dizziness, tight chest, earache.

17. Since the onset of your problem, has your participation in the following activities decreased? If so...estimate percentage of pain interference in:

	%	Description
Physical exercise	_____	_____
Leisure/social	_____	_____
Sleeping	_____	_____
Relationships	_____	_____
Housework & chores	_____	_____
Eating normal foods	_____	_____
Talking	_____	_____

18. What other treatments have you had for your chief complaints and who was or is treating doctor or provider? Please provide short, concise answers since details may be discussed at your appointment.

<u>PROBLEM</u>	<u>TREATMENT</u>	<u>DOCTOR OR PROVIDER</u> (Name and Specialty)

19. Which of the treatments provided relief?

Comments: _____

20. What do you think is the cause of your pain?

21. What other painful or significant medical or dental conditions have you been treated for in the past two years (other than your present problem)? Example: arthritis, ulcer, trauma, back pain, heart condition, diabetes, depression

a _____ b _____ c _____

d _____ e _____ f _____

22. List your most recent Hospitalizations or Surgeries (of any type):

<u>Date</u>	<u>Reason</u>	<u>Treatment</u>

23. Have you been or do you plan to be involved in legal action regarding your pain? ___ Yes ___ No

Explain: _____

24. Please check health care providers you have seen or consulted for your present condition:

<input type="checkbox"/> Acupuncturist	<input type="checkbox"/> ENT Physician	<input type="checkbox"/> Neurosurgeon	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Allergist	<input type="checkbox"/> Endocrinologist	<input type="checkbox"/> Ophthalmologist	<input type="checkbox"/> Surgeon
<input type="checkbox"/> Anesthesiologist	<input type="checkbox"/> Family Physician	<input type="checkbox"/> Oral Surgeon	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Gynecologist	<input type="checkbox"/> Dentist	<input type="checkbox"/> Internist
<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Rheumatologist	<input type="checkbox"/> Neurologist	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Dermatologist	<input type="checkbox"/> Pain/Rehab Center		
<input type="checkbox"/> Pain/Rehab Center	<input type="checkbox"/> Orthopedic Surgeon		

25. Which provider provided best relief? _____

What treatment? _____

29. What is/are the most effective pain medication(s) you have utilized?

30. How often do you exercise? _____

31. What type of exercise do you participate in?

32. When you use the following, how much do you take in a day?

Coffee ___ cups/day tobacco ___ cigarettes/day other _____
Cola ___ glasses/day beer ___ 12 oz. cans/day _____
Wine ___ glasses/day liquor ___ oz/day _____

33. Does your condition awaken you from or prevent sleep?
Yes ___ No ___

Describe: _____

Do you feel you get adequate sleep? Yes ___ No ___ How many hours a night? _____

Do you feel rested after sleeping? Yes ___ No ___ Are you a restless sleeper? Yes ___ No ___

34. Are you generally calm and relaxed, or tense and uptight? (circle answer)

A. Are you feeling depressed? Yes No

B. Are you feeling anxious? Yes No

C. Are there major stressor in your life? Yes No

If you answered yes to any of the above (A,B,C) please explain briefly: A. _____

B. _____

C. _____

35. Does an increase in stress, anxiety or depression seem to make your pain worse? Yes ___ No ___ Please explain:

36. Have you noticed clenching or grinding your teeth or other oral habits that increase pain? Yes ___ No ___ When? Under stress or tension ___ While sleeping ___ Other _____
Describe: _____

37. Do you feel that clenching or grinding your teeth causes or contributes to your pain? Yes ___ No ___ Sometimes ___

38. Have you experienced any of the following:

___ divorce
___relocated/moved
___separation from spouse
___death of friend or loved one
___serious illness friend or loved one
___chemical or alcohol dependency
___marriage
___job change
___being fired
___problems with children
___Abuse: emotional, physical, sexual
___re-marriage
___job dissatisfaction
___financial troubles
___other

39. Do you think you drank more beer, wine, or liquor in the past year because of your pain? Yes No If yes, what?

40. Have you ever been told you have a problem with alcohol or drugs?
 Yes No
41. How would you describe your marital relationship now?
a. very satisfactory c. unsatisfactory
b. satisfactory d. very unsatisfactory
42. Do you consider yourself a religious person? Yes No
43. Do you have family member(s) or close friend(s) who has or has had a pain problem? Yes No If so, what type?

44. What would you be able to do differently if you were out of pain?

45. What percentage of pain relief would be acceptable from treatment?

46. What do you expect from your encounter with the Facial Pain Center?

47. Have you considered what you would do in the event that your pain would not be eliminated or significantly improved?

48. What are you willing to do to improve?

49. What are you not willing to do to improve?

On the "full body" diagrams below, indicate other areas where you commonly have significant pain not discussed above.

Number the areas in order of intensity, the worst area being #1, and so on. Provide a brief description please, and note how long these pain conditions have been present, and if they were in the past or are currently under the care of a physician, chiropractor, etc.

