HEAD, NECK, FACIAL AND TMJ PAIN
PATIENT QUESTIONAIRE FORM

DR. STEVEN CLOAD
SOUTHCENTRE MALL
155, 100 ANDERSON ROAD SE
CALGARY ALBERTA T2J 3V1
(403) 278 - 1415

PATIENT INFORMATION DATE: _____

LAST NAME:_____ ☐MR ☐ MRS ☐ MS ☐ DR.
FIRST NAME:_____INITIAL_____
PREFERRED NAME:_____ MALE ☐ FEMALE ☐

ADDRESS: _____
CITY: _____PROVINCE:
POSTAL CODE: _____
PHONE HOME: _____
BUS #: _____

BIRTH DATE: _____ _____ _____
(day) (month) (year)
AHC # :
EMPLOYER: _____
OCCUPATION: _____
MARITAL STATUS: _____
SPOUSE'S EMPLOYER:_____

PARENTS NAME (IF UNDER AGE 18): _____
ADDRESS: _____
PARENTS BUS #: _____

PHYSICIAN NAME: _____
PHONE: _____ ADDRESS: _____

DENTIST NAME: _____
PHONE: _____ ADDRESS: _____

WHO REFERRED YOU TO THIS OFFICE?: _____

INSURANCE INFORMATION (Must be completed before examination date)
Dental Insurance

Insured Name: _____ Insured D.O.B. _____

Employer: _____ Policy #: _____

ID/Certificate #: _____ Insurance Co.: _____

Medical Insurance

Insured Name: _____

Employer: _____ Policy #: _____

Insurance Co. _____ Address: _____

If your condition / pain is due to a motor vehicle accident, please complete this section:

Motor Vehicle Insurance (registered owner of vehicle's insurance)

Insured Name: _____ Policy # _____ Claim # _____

Insured Co: _____ Address: _____

Phone #: _____ Contact Person: _____

Adjuster (not agent): _____ Adjuster Co: _____

Adjuster Address: _____ Adjuster Phone #: _____

Legal

Lawyer's Name: _____ Law Firm: _____

Address: _____ Phone #: _____

Postal Code: _____

We do not accept workers compensation claims.

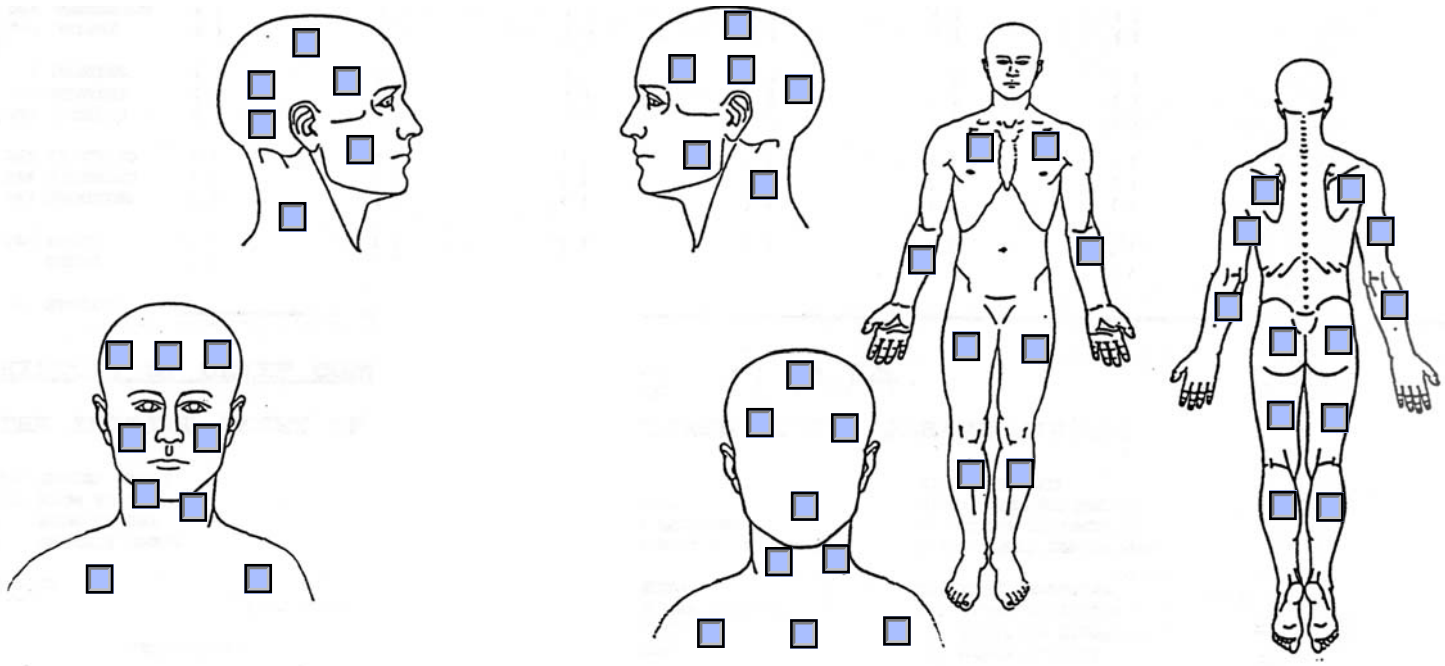
_____
(PATIENT INITIALS)

SYMPTOMS

PLEASE CHECK ANY/ALL SYMPTOMS THAT YOU HAVE EXPERIENCED:

☐ Headache	☐ Neck Ache	☐ Earache
☐ Shoulder Pain	☐ Facial Pain	☐ Eye Pain
☐ Neck Noise	☐ Jaw Joint Noise	☐ Ringing, Buzzing Ears
☐ Jaw/Facial Pain with Chewing	☐ Jaw/Facial Pain with Yawning	☐ Limited Jaw Opening
☐ Jaw Locking	☐ Jaw Fatigue	☐ Jaw Stiffness
☐ Facial Numbness	☐ Facial Swelling	☐ Limited Movement of Neck
☐ Clenching Teeth	☐ Uncomfortable Bite	☐ Cheek Biting
☐ Ear Congestion	☐ Dizziness	☐ Jaw Muscle Tremor
☐ Teeth Ache	☐ Jaw Dislocates	☐ Swelling in Neck
☐ Back Pain	☐ Tingling/Numbness in Hands/Arms	☐ Tinnitus
☐ Difficulty Swallowing	☐ Insomnia/Snoring	

Please indicate the location of your pain on the following diagrams. If your pain starts in one area but radiates to others, please indicate by writing it below with descriptions.



(Back of head)

Please list the 4 most important symptoms you wish to resolve from the list above

1. _____
2. _____
3. _____
4. _____

_____
PATIENT INITIAL

For each of the pains you have outlined, please indicate the words you feel best describe your pain.

Severity	**Mild (1)**	**Moderate (2)**	**Severe (3)**
Headache	1☐	2☐	3☐
Jaw ache	1☐	2☐	3☐
Neck pain	1☐	2☐	3☐
Shoulder pain	1☐	2☐	3☐
Facial pain	1☐	2☐	3☐

Frequency	**Constant (1)**	**Frequent (2)**	**Occasional (3)**
Headache	1☐	2☐	3☐
Jaw ache	1☐	2☐	3☐
Neck pain	1☐	2☐	3☐
Shoulder pain	1☐	2☐	3☐
Facial pain	1☐	2☐	3☐

Duration	**Seconds (1)**	**Minutes (2)**	**Hours (3)**	**All day (4)**	**Weeks (5)**
Headache	1☐	2☐	3☐	4☐	5☐
Jaw ache	1☐	2☐	3☐	4☐	5☐
Neck pain	1☐	2☐	3☐	4☐	5☐
Shoulder pain	1☐	2☐	3☐	4☐	5☐
Facial pain	1☐	2☐	3☐	4☐	5☐

CAUSE OF CHIEF CONCERNS

The initial cause of my problem was:

☐VIRAL INFECTION
☐STRESSFUL PERIOD
☐DENTAL WORK
☐OTHER HEAD/NECK PAIN
☐GRADUAL ONSET
☐CHEWING INCIDENT
☐BLOW TO THE HEAD
☐UPON AWAKENING
☐PREGNANCY
☐PHYSICAL FATIGUE
☐VEHICLE ACCIDENT
☐GENERAL ANESTHETIC
☐CERTAIN FOODS
☐SUDDEN ONSET
☐TOOTH EXTRACTION
☐NEW DENTURES
☐ILLNESS
☐MENSTRUAL PERIOD
☐DENTAL ANESTHETIC
☐BLOW TO THE JAW
☐OTHER _____

My problem is made worse by:

☐YAWNING
☐TALKING
☐SLEEP
☐PHYSICAL ACTIVITY
☐STRESS
☐SWALLOWING
☐SINGING
☐OPENING WIDE
☐WALKING
☐SPECIFIC FOOD
☐PREGNANCY
☐NO REASON

☐MENSTRUAL PERIOD ☐ JAW MOVEMENT ☐HEAD MOVEMENT
☐FATIGUE ☐ DENTAL VISIT ☐ COUGHING
☐CHEWING ☐BENDING OVER ☐OTHER _____

PATIENT INITALS

What decreases your pain? _____

_____

_____

Briefly describe how your problem started and how it reached this state.

_____

_____

SLEEP PATTERN

Do you snore ?	☐ Y	☐ N
Have you been diagnosed with sleep apnea?	☐ Y	☐ N
Have you had a sleep examination in a sleep centre?	☐ Y	☐ N
Do you gasp for breath during the night?	☐ Y	☐ N

JAW PAIN AND FUNCTION

Please check off the problems that you experience and the side(s) it relates to. Please select left, right or check both boxes if it applies:

LEFT RIGHT

☐ AND/OR ☐ PAIN ON OPENING
☐ AND/OR ☐ PAIN ON OPENING WIDE (YAWNING)
☐ AND/OR ☐ PAIN ON LEFT MOVEMENT
☐ AND/OR ☐ PAIN ON RIGHT MOVEMENT
☐ AND/OR ☐ PAIN ON CLOSING

☐ AND/OR ☐ PAIN WHILE CLENCHING
☐ AND/OR ☐ PAIN WHILE CHEWING
☐ AND/OR ☐ PAIN AT REST

☐ AND/OR ☐ JAW POPPING, CLICKING ON OPENING
☐ AND/OR ☐ JAW POPPING, CLICKING ON CLOSING
☐ AND/OR ☐ JAW PREVIOUSLY POPPED / CLICKED ON OPENING
☐ AND/OR ☐ JAW PREVIOUSLY POPPED / CLICKED ON CLOSING
☐ AND/OR ☐ JAW GRINDING, GRATING NOISES

☐ JAW GOES LEFT ON OPENING JAW
☐ GOES RIGHT ON OPENING JAW
☐ "ZIGZAGSZ'ZZ" ON OPENING

☐ AND/OR ☐ LIMITED OPENING OF JAW
☐ AND/OR ☐ JAW SOMETIMES LOCKS CLOSED
☐ AND/OR ☐ JAW SOMETIMES LOCKS OPEN

☐ CAN'T MOVE JAW LEFT
☐ CAN'T MOVE JAW RIGHT)
☐ OTHER _____

Do neck movements or postural changes increase facial, ear or head pain? Y ☐ N ☐
Do your job / daily activity involve poor head, neck or back posture? Y ☐ N ☐
Do you have difficulty finding a comfortable position at night? Y ☐ N ☐
Any previous examinations / tests for your spine? Y ☐ N ☐
If yes, specify ____

____
PATIENT INITALS

PREVIOUS TREATMENT

Please indicate other practitioners i.e.: Physicians, Medical Specialists, Chiropractors, Physical Therapists, etc. that you are seeing or have seen for this problem.

Practitioner Name: ____
Type of Practitioner: ____
Type of Treatment: ____
Result of Treatment: ____
Date of Treatment ______________________ Currently being treated? Y ☐ N ☐

Practitioner Name: ____
Type of Practitioner: ____
Type of Treatment: ____
Result of Treatment: ____
Date of Treatment ______________________ Currently being treated? Y ☐ N ☐

Practitioner Name: ____
Type of Practitioner: ____
Type of Treatment: ____
Result of Treatment: ____
Date of Treatment ______________________ Currently being treated? Y ☐ N ☐

Practitioner Name: ____
Type of Practitioner: ____
Type of Treatment: ____
Result of Treatment: ____
Date of Treatment ______________________ Currently being treated? Y ☐ N ☐

Practitioner Name: ____
Type of Practitioner: ____
Type of Treatment: ____
Result of Treatment: ____
Date of Treatment ______________________ Currently being treated? Y ☐ N ☐

____
PATIENT INITALS

MEDICAL INFORMATION

Height: _____Weight: _____

Please check the following conditions which apply to your medical history.

ALLERGIES
- ☐ Hay fever
- ☐ Environmental
- ☐ Drug
- ☐ Food
- ☐ Specify _____

ARTIFICAL IMPLANTS
- ☐ Heart pacemaker
- ☐ Heart valve
- ☐ Joint prosthesis
- ☐ Other _____

ARTHRITIS
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Other _____

BLOOD
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Sickle cell anemia
- ☐ Other _____

ENDROCRINE
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Parathyroid disease
- ☐ Thyroid disease

EYE
- ☐ Glaucoma
- ☐ Other _____

GYNECOLOGICAL
- ☐ Hysterectomy
- ☐ Hormone replacements
- ☐ Menopause
- ☐ PMS
- ☐ Birth control pill
- ☐ Other _____

HEART / CIRCULATORY
- ☐ Arteriosclerosis
- ☐ Heart defects
- ☐ Coronary artery disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Other _____

IMMUNE
- ☐ Lupus
- ☐ Connective tissue disease
- ☐ Chronic fatigue syndrome
- ☐ HIV
- ☐ Aids
- ☐ Rheumatic fever

URINARY
- ☐ Bladder infections
- ☐ Blood in urine
- ☐ Kidney disease
- ☐ Other _____

LIVER DIAEASE
- ☐ Cirrhosis of the liver
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other _____

RESPIRATORY
- ☐ Asthma
- ☐ Chronic colds
- ☐ Emphysema
- ☐ Frequent cough
- ☐ Sinus
- ☐ Post nasal drip
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ Other _____

MUSCLE / BONE
- ☐ Muscular dystrophy
- ☐ Fibrositis
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Chronic back pain
- ☐ Leg length discrepancy
- ☐ Other _____

NERVE
- ☐ Cerebral palsy
- ☐ Epilepsy
- ☐ Neuralgia
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Stroke
- ☐ Other _____

NUTRITIONAL
- ☐ Nutrition deficiencies
- ☐ Overweight
- ☐ Underweight
- ☐ Food sensitive / intolerances

Please specify _____
- ☐ Other _____

_____
PATIENT INITALS

BEHAVIORAL
- ☐ Counseling
- ☐ Psychological care
- ☐ Psychiatric care

Please specify _____

- ☐ Anxiety
- ☐ Depression
- ☐ Nervous breakdown
- ☐ Phobia
- ☐ Alcoholism
- ☐ Drug addiction
- ☐ Relaxation therapy
- ☐ Stress management
- ☐ Other _____

SKIN / MUCOSAL
- ☐ Eczema
- ☐ Psoriasis
- ☐ Scleroderma
- ☐ Other _____

GASTROINTESTINAL
- ☐ Colitis
- ☐ Ulcers
- ☐ Canker sores
- ☐ Irritable bowel syndrome

- ☐ Hiatus hernia
- ☐ Anorexia
- ☐ Bulimia
- ☐ Gall bladder
- ☐ Other _____

Growths
- ☐ Tumor
- ☐ Cancer

Please specify _____

- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Other _____

MEDICATION

All medication currently being taken: (including prescription, homeopathic, supplements & vitamins)

Name of drug	**Taken for how long**	**Reason for use**	**Result**

Medications you have previously taken for this problem:

Name of drug	**Taken for how long**	**Reason for use**	**Result**

_____
PATIENT INITALS

DENTAL HISTORY

When was your last dental examination / check-up? _____

Do you have any missing teeth that need replacement? Yes ☐ No ☐

Have you ever been told that you need braces or jaw surgery? Yes ☐ No ☐

Do you have or have you ever had any of the following:

☐Bite adjustments ☐ Splint treatment Date:_____
☐Extensive crown / bridge work ☐ Removal of wisdom teeth
☐Gum treatment
☐Orthodontic treatment

Details:_____
_____
_____

OCCLUSION (HOW YOUR TEETH BITE TOGETHER)

Please check off the problems that apply to you:

☐ My teeth fit together evenly (if not, select from the following)
☐ My bite feels off centre
☐ My teeth touch more on the right side than on the left
☐ My teeth touch more on the left side than on the right
☐ My back teeth touch more than my front teeth
☐ My front teeth touch more than my back teeth
☐ I feel that my lower jaw has shifted forward
☐ I feel that my lower jaw has shifted backward
☐ I feel that one tooth hits upon closing my mouth sooner than the rest
☐ Other _____

GRINDING / CLENCHING

I am aware of doing the following:

☐ Day time grinding of teeth ☐ Night time grinding of teeth
☐ Day time clenching of teeth ☐ Night time clenching of teeth
☐ Day time clenching of jaw muscles ☐ Night time clenching of jaw muscles

_____
PATIENT INITALS

OCCUPATIONAL CONCERNS

My normal day includes:

Frequent use of the telephone	Y ☐	N ☐
Cradling the phone between my ear and shoulder	Y ☐	N ☐
Prolonged use of a computer / screen	Y ☐	N ☐
Prolonged sitting in one position	Y ☐	N ☐
Prolonged driving	Y ☐	N ☐
Poor work posture	Y ☐	N ☐
Repetitive patterns of movements / activity	Y ☐	N ☐
Holding or turning my head away from centre for prolonged periods of time	Y ☐	N ☐
Carrying a heavy briefcase / back-pack	Y ☐	N ☐
Excessive talking / yelling	Y ☐	N ☐
Lifting of heavy objects	Y ☐	N ☐

HABITS / ACTIVITIES (check what applies)

☐ Fingernail biting	☐ Cheek chewing	☐ Jutting jaw forward
☐ Clicking jaw habit	☐ Clenching teeth	☐ Grinding teeth
☐ Pencil / pen chewing	☐ Gum chewing	☐ Holding chin in palm of hands
☐ Scuba diving	☐ Contact sports	☐ Biking
☐ Singing		

☐ Playing musical instrument with mouth (specify) _____

SLEEP HABITS

I sleep on my:

☐ Left side	☐ I wake up from sleep by pain
☐ Right side	☐ I use more than one pillow
☐ Stomach	☐ I snore
☐ Back	☐ I sleep with my mouth open
☐ In all positions	☐ I wake up my partner

_____
PATIENT INITALS

If there is anything about your condition that these questions did not ask, give you an opportunity to write about or you feel may be of help in diagnosing or treatment of your problem please feel free to complete this section provided.

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
PATIENT INITIALS

If you are seeing us because of a motor vehicle accident, please complete the following section.

ACCIDENT DETAILS

Date of accident: _____ Time: _____

Type of vehicle you were driving : _____

Other vehicle(s) involved: _____

Location: _____

Please describe the accident:

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
PATIENT INITALS

I was:

☐ The driver of the vehicle

☐ A passenger in the vehicle ☐ In the front seat ☐ In the back seat ☐ Left ☐ Right ☐ Middle

I was wearing: ☐ Seat belt ☐ No seat belt

At the point of impact, I was facing: ☐ Forward ☐ Left ☐ Right ☐ Behind

At the time of the accident, do you remember if you hit your:

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

on the
☐ Steering wheel
☐ Windshield
☐ Passenger side window
☐ Driver side window
☐ Headrest
☐ Dashboard
☐ Seat
☐ Roof
☐ Loose object in car
☐ Other person in car
☐ Did your air bag deploy

☐ Do you remember bracing against the steering wheel
☐ Were you rendered unconscious
☐ Were you aware that you were going to be hit
☐ Were you clenching your teeth at time of impact
☐ Did you fracture your teeth or bite your tongue
☐ Do you remember receiving a whiplash type of injury
☐ Do you remember receiving a sideways whiplash injury

_____
PATIENT INITIAL

How soon after the accident did you notice the following symptoms?

	Minutes (1)	Days (2)	1 week (3)	1-3 months later (4)	more than 3 months later (5)
Headache	1☐	2☐	3☐	4☐	5☐
Neck ache	1☐	2☐	3☐	4☐	5☐
Shoulder pain)	1☐	2☐	3☐	4☐	5☐
Facial pain	1☐	2☐	3☐	4☐	5☐
Ear ache	1☐	2☐	3☐	4☐	5☐
Teeth ache	1☐	2☐	3☐	4☐	5☐
Neck noise	1☐	2☐	3☐	4☐	5☐
Jaw joint noise	1☐	2☐	3☐	4☐	5☐
Limited jaw opening	1☐	2☐	3☐	4☐	5☐
Pain with chewing, yawning etc.	1☐	2☐	3☐	4☐	5☐
Ringing,buzzing ears	1☐	2☐	3☐	4☐	5☐
Dizziness	1☐	2☐	3☐	4☐	5☐
Facial numbness	1☐	2☐	3☐	4☐	5☐
Facial swelling	1☐	2☐	3☐	4☐	5☐
Back pain	1☐	2☐	3☐	4☐	5☐
Jaw dislocates	1☐	2☐	3☐	4☐	5☐
Uncomfortable bite	1☐	2☐	3☐	4☐	5☐
Limited movement of neck	1☐	2☐	3☐	4☐	5☐
Tingling / numbness in hands / arms	1☐	2☐	3☐	4☐	5☐

_____
PATIENT INITALS

How often did you experience the following symptoms before your accident?

	Daily (1)	more than once a week (2)	once/week (3)	once/month (4)	never (5)
Headache	1☐	2☐	3☐	4☐	5☐
Neck ache	1☐	2☐	3☐	4☐	5☐
Shoulder pain	1☐	2☐	3☐	4☐	5☐
Facial pain	1☐	2☐	3☐	4☐	5☐
Ear ache	1☐	2☐	3☐	4☐	5☐
Teeth ache	1☐	2☐	3☐	4☐	5☐
Neck noise	1☐	2☐	3☐	4☐	5☐
Jaw joint noise	1☐	2☐	3☐	4☐	5☐
Limited jaw opening	1☐	2☐	3☐	4☐	5☐
Pain with chewing, yawning etc.	1☐	2☐	3☐	4☐	5☐
Ringing,buzzing ears	1☐	2☐	3☐	4☐	5☐
Dizziness	1☐	2☐	3☐	4☐	5☐
Facial numbness	1☐	2☐	3☐	4☐	5☐
Facial swelling	1☐	2☐	3☐	4☐	5☐
Back pain	1☐	2☐	3☐	4☐	5☐
Jaw dislocates	1☐	2☐	3☐	4☐	5☐
Uncomfortable bite	1☐	2☐	3☐	4☐	5☐
Limited movement of neck	1☐	2☐	3☐	4☐	5☐
Tingling / numbness in hands / arms	1☐	2☐	3☐	4☐	5☐

Are there any other factors you feel are significant with your accident?

_____

_____

_____

_____

_____

_____
PATIENT INITALS

Did you go to the hospital? ☐ Yes (881) ☐ No

Were you hospitalized? ☐ Yes ☐ No

Date that Jaw / facial problems were reported to doctor _____

Please describe any previous traumas, to the head, neck or jaw. (sports injury, assault accident etc.)

_____
_____
_____
_____

Degree of improvement

Please grade your degree of pain since your motor vehicle accident on a scale of 1 – 100.

Neck pain	_____%	☐ worse	☐ better
Shoulder pain	_____%	☐ worse	☐ better
Headache	_____%	☐ worse	☐ better
Jaw pain	_____%	☐ worse	☐ better
Back pain	_____%	☐ worse	☐ better
Other	_____%	☐ worse	☐ better

If you have had a previous accident, please describe (include date of accident):

Date and Description: _____
_____
_____
_____
_____
_____
_____

Are you currently working? ☐ Yes ☐ No

Return to work date? _____ ☐ Full time ☐ Part time ☐ % of time_____

On disability insurance? ☐ Yes ☐ No

If yes, when are you planning on returning to work? _____

_____
PATIENT INITALS

* Please note that an administrative charge will be payable by yourself if any reports, letters, forms etc. are required to be completed by yourself or a third party. We will notify you of any fee associated with any request before the request is fulfilled.