SOUTH RIDING
ORAL & IMPLANT SURGERY

Today's Date:_____

Patient Name: _____ **Date of Birth:** _____

Who referred you for this evaluation? _____

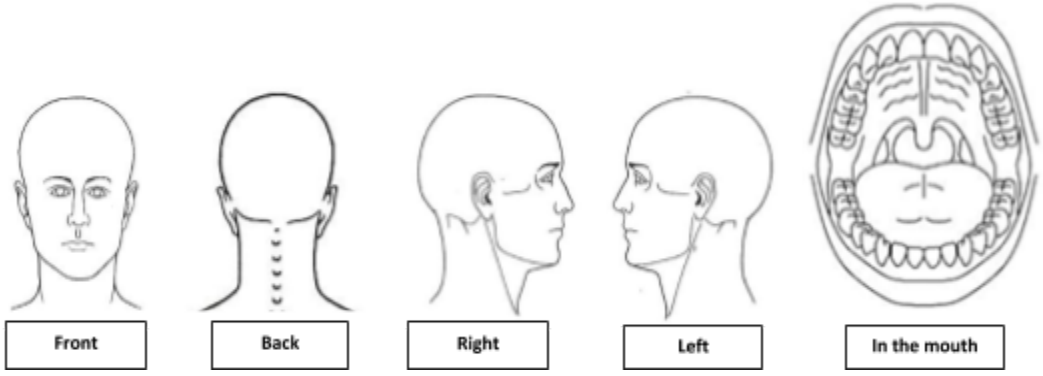
Your Chief Concern(s):

1. **Why are you here? Describe your pain or dysfunction(s).**

2. **When and how did your pain or dysfunction(s) start?**

3. **Have you had a recent injury to your head, neck or jaw?** ☐ **Yes** ☐ **No**
   - If yes, please describe:

4. **Where is your pain located?** *Please use the pictures to mark location(s).*

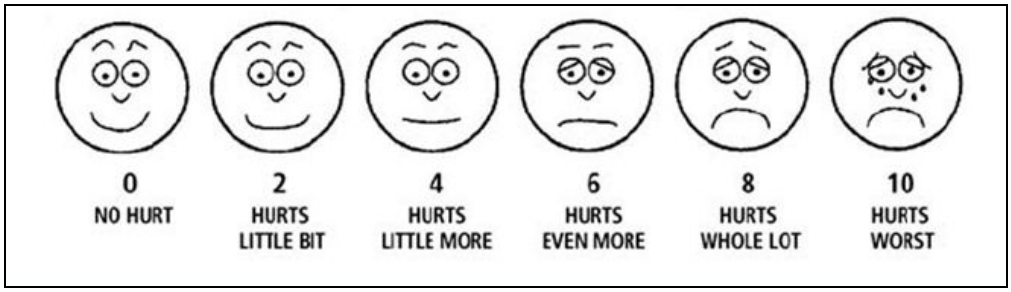


5. **Mark the level intensity of pain from the area that is the <u>main reason for your visit</u>?**

Today
0 10

At its Worst
0 10

On Average
0 10



6. Which word(s) best describe your pain or dysfunction(s):

❑ Sharp ❑ Burning ❑ Electric-like ❑ Aching ❑ Throbbing ❑ Dull
❑ Pressing ❑ Pulsing ❑ Stabbing ❑ Itching ❑ Tingling ❑ Numbness
❑ Other:

7. **How often do your symptoms occur?**

❑ Daily (How many times a day?) _____
❑ Weekly (How many times a week?) _____
❑ Monthly (How many times a month?) _____

8. **How long do the symptoms typically last (check all that apply)?**

❑ Constant ❑ Comes & Goes ❑ Days
❑ Seconds ❑ Minutes ❑ Hours

9. **When is the pain worse?**

❑ When I wake up ❑ Midday ❑ Evening ❑ During meals ❑ All day
❑ Other:

10. What starts or triggers the pain or dysfunction?

What makes it worse?

What makes it better?

11. **Do you have any pain-free days?** ☐ **Yes** ☐ **No**

- If yes, please describe: _____

12. **When were you last completely pain free?** _____

13. <u>In the last month</u>, how much has this interfered with your normal daily activities including work, recreational, social and family? *(circle below)*

No Interference *Unable to carry on any activities*

1 2 3 4 5 6 7 8 9 10

- What activities does this pain limit you from doing?

14. **Does your problem affect your ability to eat?** ☐ **Yes** ☐ **No** ☐ **Sometimes**

15. Do you have any of the following or other symptoms when the pain is present? (check all that apply)

❑ Jaw stiffness ❑ Jaw fatigue ❑ Tooth pain ❑ Ear pain ❑ Throat/neck pain

❑ Swelling ❑ Nausea ❑ Vomiting ❑ Hearing changes ❑ Unusual jaw movement

❑ Headache ❑ Numb/tingling ❑ Visual changes ❑ Bite changes ❑ Ear fullness/stuffiness

❑ Other (please describe):

16. Does your jaw joint (TMJ) make noises? ☐ **Yes** ☐ **No** ☐ **Sometimes**

- If yes or sometimes, what type (check all that apply)?

❑ Popping ❑ Clicking

❑ Grating/Grinding ❑ Other (please describe):

17. How long has the jaw joint (TMJ) noise been present?

❑ Days ❑ Weeks ❑ Months ❑ Years ❑ Other (please describe):

18. Any recent changes to the noise? ☐ **Yes** ☐ **No**

❑ Louder ❑ Softer ❑ More frequent ❑ Less Frequent

❑ Stopped ❑ More painful ❑ Less painful

19. Does your jaw get 'stuck,' 'locked,' or 'go out?'

❑ No ❑ Yes, it catches sometimes but I'm able to open/close it

❑ Yes, unable to close ❑ Yes, unable to open

- If this happens on a recurring basis, how often does it occur?

❑ Daily (How many times a day?) _____

❑ Weekly (How many times a week?) _____

❑ Monthly (How many times a month?) _____

20. Have you previously been treated for a jaw joint problem? If so, when? _____

- Who have seen for this condition?

❑ Dentist ❑ Primary Care ❑ Neurology ❑ ENT ❑ Pain Clinic

❑ Oral Surgeon ❑ Pain Clinic ❑ Physical Therapy ❑ Chiropractor

21. What treatments and/or medications have you received for the problem(s) and did they help?

22. What do you think is causing your pain/problem(s) and what do you think needs to be done?

23. Why did you decide to seek care at this time?

Habits/Behaviors

1. **Do you engage in any of the following activities during the day?**

❑ Jaw clenching ❑ Nail biting ❑ Cheek biting
❑ Teeth grinding ❑ Jaw posturing (sideways/forward) ❑ Lip biting
❑ Resting teeth together ❑ Biting/chewing object ❑ Other (please describe):

2. **Do you clench or grind your teeth during sleep?** ☐ Yes ☐ No ☐ Do not know

- If yes, how do you know?

❑ Self-aware ❑ Told by dentist/doctor ❑ Told by others

❑ Other (please describe):

3. **In a 24-hour period, how much time would estimate that your teeth are touching (clenching or resting together):**

❑ A few seconds ❑ An hour ❑ All day
❑ A few minutes ❑ Several hours ❑ Some days more than others
❑ Other (please describe):

4. **Do you chew gum?** ☐ Yes ☐ No

- If yes, how often? _____ How long per piece? _____

5. **Do you regularly engage in the following activities (check all that apply)?**

❑ Desk/bench work ❑ Computer use
❑ Reading ❑ "Smart" device use
❑ Computer use ❑ Resting phone between shoulder/ear
❑ Other static head/neck activities:

- If yes, estimate how many hours per day that you engage in these activities:

_____

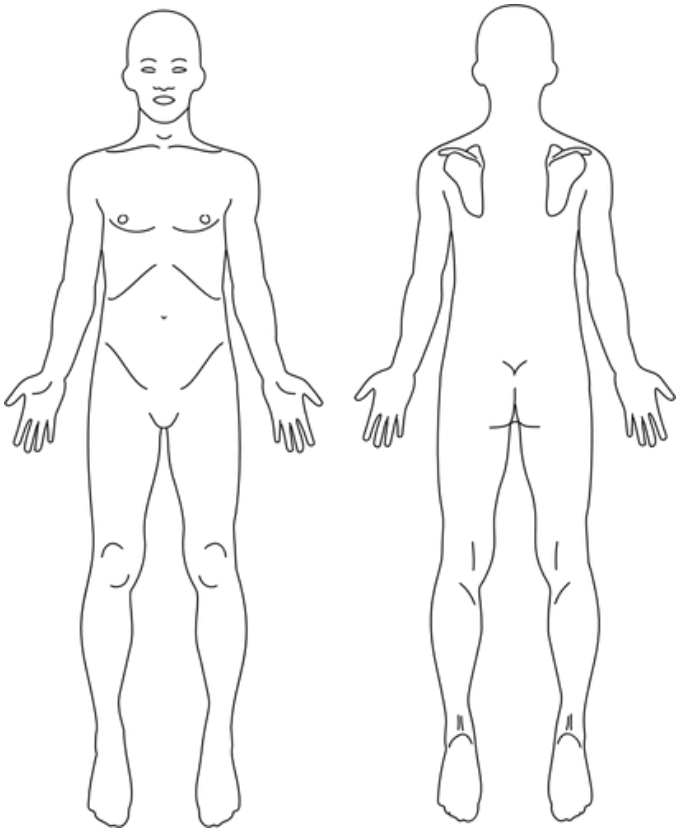
Other Body Pain Conditions:

1. **Do you have neck pain?** ☐ Yes ☐ No **Neck Sounds?** ☐ Yes ☐ No **When did it start? _____**

2. **What is the overall level of your <u>total body pain</u> ?** (circle one for each line below)

	No discomfort										*Worst pain imaginable*
Today	0	1	2	3	4	5	6	7	8	9	10
At its Worst	0	1	2	3	4	5	6	7	8	9	10
On Average	0	1	2	3	4	5	6	7	8	9	10

3. Please outline/draw the locations of <u>ALL BODY PAIN(s)</u> that you are experiencing:



List all your pain problems. (Worst first)

1. _____

2. _____

3. _____

4. _____

5. _____

Which pain occurred first?

_____

4. Have you been diagnosed with any of the following conditions?

- ❑ Fibromyalgia
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Gastroesophageal reflux disease (GERD)
- ❑ Whiplash
- ❑ Chronic pelvic pain disorder
- ❑ Traumatic Brain Injury (TBI)/Concussion

5. **Who is treating you for these pains?**

- ❑ Primary Care Physician
- ❑ Pain Medicine Physician
- ❑ Ear, Nose, Throat Physician
- ❑ Neurologist
- ❑ Physical Therapist
- ❑ Behavioral Health Provider
- ❑ Chiropractor
- ❑ Massage Therapist
- ❑ Acupuncturist
- ❑ Other (please list):

❑

6. Do you have any of the following ear symptoms?

Fullness / Stuffiness	Ringing	Other sounds	Pain / Discomfort
❑ Right	❑ Right	❑ Right	❑ Right
❑ Left	❑ Left	❑ Left	❑ Left

7. Do you have dizziness or lightheadedness that is <u>not</u> associated with a headache? ☐ Yes ☐ No

8. **Do you have any numbness and tingling in any of the locations below?**

Around the mouth	Head/Face	Arms/fingers	Legs/toes
❑ Right	❑ Right	❑ Right	❑ Right
❑ Left	❑ Left	❑ Left	❑ Left

- ❑ Other: (please list):

Headache History

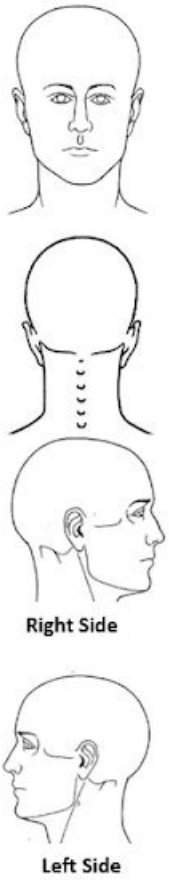
1. **Do you experience headaches?** ☐ Yes ☐ No

2. **Do others in your family have a history of headache?** ☐ Yes ☐ No

3. **When (what age) was your first ever headache?** _____

4. **Please describe each type of headache you experience in the chart below:**

	#1	#2	#3
Location: (also draw on diagrams)			
**Pain Description: (sharp, dull, stabbing, etc.)			
Average pain level: (1-10)	**/10**	**/10**	**/10**
How often do they occur? (daily, weekly, etc.)			
How long do they last? (minutes, hours, days, etc.)			
What starts (triggers) your headache?			



*** Common headache pain descriptors: Dull Sharp Pressing Stabbing Throbbing Burning*

5. **With your headache(s), do you experience:**

- ❏ Nausea
- ❏ Vomiting
- ❏ Light sensitivity
- ❏ Sound sensitivity
- ❏ Dizziness
- ❏ Other: (please describe)
- ❏ Eye tearing
- ❏ Eyelid droop
- ❏ Nasal congestion
- ❏ Runny nose
- ❏ Face/neck sweating
- ❏ Altered sensation: (please describe)

6. **How do you manage your headaches? Please include medications.**

7. **Who have you seen for your headache(s)?** _____

Personal/Mind Body History

1. **What is your occupation?** _____

2. **Marital status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Children?:** ☐ Yes ☐ No

3. **Are there any special needs or circumstances involving you, your family, or your job?** ☐ Yes ☐ No

4. **Exercise level:** ☐ None ☐ Slight ☐ Moderate ☐ Active **Any activity limitations?** _____

5. **Do you use any of the following?**

Tobacco ☐ Yes ☐ No Type: ☐ Smoke/Vape ☐ Smokeless How much/How often? _____

Alcohol ☐ Yes ☐ No How much/How often? _____

Caffeine ☐ Yes ☐ No Type: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Chocolate ☐ Other
How much/How often? _____

6. **Are you well hydrated?** ☐ Yes ☐ No ☐ Unknown **How much water do you drink per day?** _____

7. **Do you skip meals?** ☐ No ☐ Breakfast ☐ Lunch ☐ Dinner **How often?** _____

   - Any unplanned weight gains or losses (in the past year)? ☐ gain ☐ loss _____ pounds

   - Approximate**: Weight:** _____ lbs. **Height:** _____ feet _____ inches **Neck Size:** _____ inches

8. **Do you have any history of the following, or other similar threatening, significantly stressful or frightening life events:** *abuse/assault (physical, emotional, sexual), childhood neglect, motor vehicle accident, near drowning, military deployment/combat, panic attacks, other***?** ☐ Yes ☐ No

9. **Please rate your overall levels of:**

Please mark your level on the lines below

	None										**Unable to function**
Stress	0	1	2	3	4	5	6	7	8	9	10
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
	None										**Uncontrollable**
Anger	0	1	2	3	4	5	6	7	8	9	10

   - What are the main drivers for these feelings (i.e. finances, work, pain, relationships, etc.)?

   - What activities help you cope with or manage these feelings?

14. **Have you ever thought of harming yourself/others?** ☐ Yes ☐ No
15. **Are you currently experiencing these feelings?** ☐ Yes ☐ No
16. **If yes, do you have a plan to carry it out?** ☐ Yes ☐ No
17. **Have you been told that you have post-traumatic stress or post-traumatic stress disorder (PTSD)?** ☐ Yes ☐ No
    - If yes, when? _____ Did you receive treatment? ☐ Yes ☐ No

Sleep History

1. **<u>In the last month</u>:**

   a. **Estimate the average total time spent sleeping (typical night): _____**

   b. **Estimate the average time it takes to fall asleep: _____**

   c. **My typical night's sleep was:**

❑ Good ❑ Fair ❑ Poor ❑ Sound ❑ Light ❑ Restless ❑ Very restless

2. **Your typical sleep position is:** ☐ Back ☐ Side ☐ Stomach ☐ Head elevated ☐ In chair

3. **Do you regularly work night shifts?** ☐ Yes ☐ No

4. **Do you work shift work or rotating shifts (including nights)?** ☐ Yes ☐ No

5. **Please check the boxes below that best describe your sleep experience:** *(over the past month)*

	Not in the last month	*Less than once a week*	*1-2 times a week*	*3-4 times a week*	*5 or more times a week*
I had trouble falling asleep	❑	❑	❑	❑	❑
I woke up several times per night	❑	❑	❑	❑	❑
I woke up earlier than I planned	❑	❑	❑	❑	❑
I had trouble getting back to sleep after waking too early	❑	❑	❑	❑	❑

d. Do you snore loudly (loud enough to be heard through walls or closed doors)? ☐ Yes ☐ No ☐ Don't know

e. **Have you ever been told you stopped breathing while sleeping?** ☐ Yes ☐ No

f. **Do you often feel tired, fatigued, or sleepy during the daytime?** ☐ Yes ☐ No

g. **Have you been diagnosed with sleep apnea?** ☐ Yes ☐ No

- If yes, are you being treated for it**?** ☐ Yes ☐ No

h. **What treatment(s) have you tried**?

❑ CPAP/APAP ❑ Dental Device ❑ Weight loss

❑ Sleep Posture ❑ Surgery ❑ Surgical Implant

If there is anything else you would like to add about your pain or sleep please use this space to elaborate: