

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**INSTRUCTIONS:**

1. Circle symptoms that you are now experiencing.
2. Place an "X" by the symptoms you have experienced in the past.

**HEAD PAIN, HEADACHE**

1. Forehead
2. Temples
3. "Migraine" type
4. Sinus type
5. Shooting pain up back of head
6. Hair and/or scalp painful to touch

**EAR PROBLEMS**

1. Hissing, buzzing or ringing
2. Decreased hearing
3. Ear pain, ear ache, no infection
4. Clogged "itchy" ears
5. Vertigo, dizziness

**EYES**

1. Pain behind eye
2. Bloodshot eyes
3. May bulge out
4. Sensitive to sunlight

**MOUTH**

1. Discomfort
2. Limited opening of mouth
3. Inability to open smoothly
4. Jaw deviates to one side
5. Locks shut or open
6. Can't find bite

**TEETH**

1. Clinching, grinding at night
2. Looseness and soreness of back teeth

**THROAT**

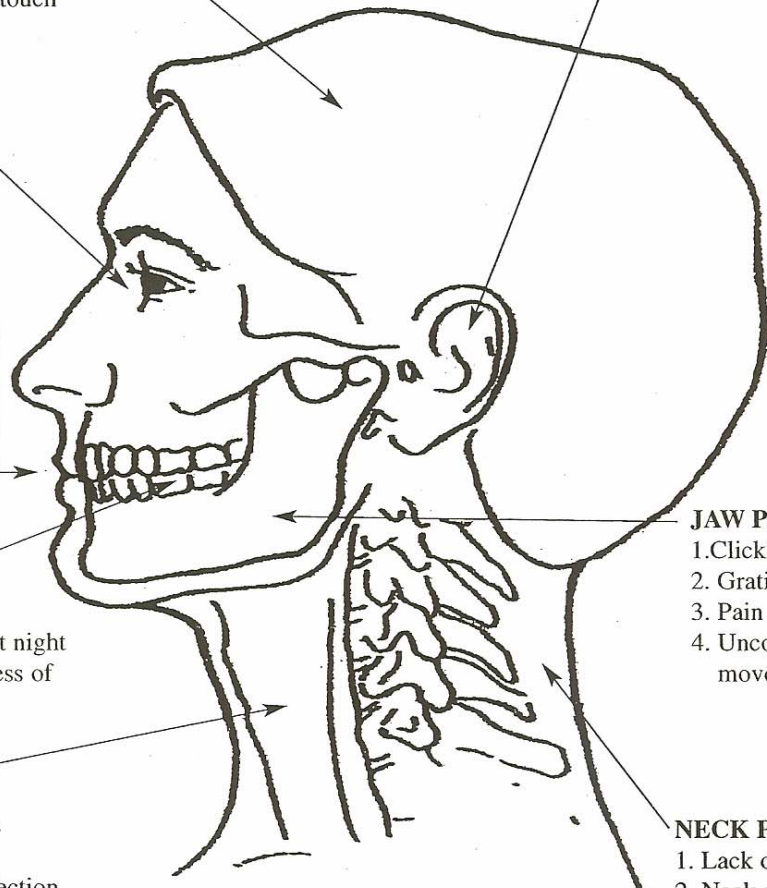
1. Swallowing difficulties
2. Laryngitis
3. Sore throat with no infection
4. Voice irregularities or changes
5. Frequent coughing or constant clearing of throat
6. Feeling of foreign object in throat constantly

**JAW PROBLEMS**

1. Clicking, popping jaw joints
2. Grating sounds
3. Pain in cheek muscles
4. Uncontrollable jaw and/or tongue movements

**NECK PROBLEMS**

1. Lack of mobility, stiffness
2. Neck pain
3. Tired sore muscles
4. Shoulder aches and backaches
5. Arm and finger numbness and/or pain



1. Onset of symptoms:                     Weeks             Months             Years
2. Severity of symptoms                 Mild                 Moderate         Severe

Explain: \_\_\_\_\_

3. Type of pain:             Sharp             Throbbing         Dull             Aching
4. Have you had recent dental work?             Crowns/Bridge         Fillings         Extractions

Other \_\_\_\_\_