ORGANIZER COMPLETE

Describe your pain(s) or problem. Then, describe your goal?____

____

When and how did it start?____

Who have you seen for it? Please circle: Dentist, Primary Care Provider, Neurology, ENT, Pain Clinic, Physical Therapy, Psychologist,Psychiatrist,Chiropractor,Other____

What treatments and/or medications have you received for it and how were they helpful ?________________________

____

INTENSITY:

1 . In the past three months, how intense was your WORST pain?

No pain — Pain as bad as could be

0 1 2 3 4 5 6 7 8 9 10

2. In the past three months, on AVERAGE, how intense was your pain?

No pain — Pain as bad as could be

0 1 2 3 4 5 6 7 8 9 10

3. In the past three months, how much has pain changed your ability to take part in RECREATIONAL, SOCIAL, and FAMILY ACTIMTIES?

No change — Extreme change

0 1 2 3 4 5 6 7 8 9 10

4. In the past three months, how much has pain changed your ability to WORK (including HOUSEWORK)?

No change — Extreme change

0 1 2 3 4 5 6 7 8 9 10

CHARACTER:

Circle the word(s) that describe your pain or problem(s). Add your own:________________________________

Sharp Burning Electric Aching Throbbing Dull Pulsing Deep Pressing Stabbing Tingling

FREQUENCY:

Does the pain come-and-go or is it present all the time (circle)?

If it comes and goes, how long do the episodes last? How many bouts per day/week/month?

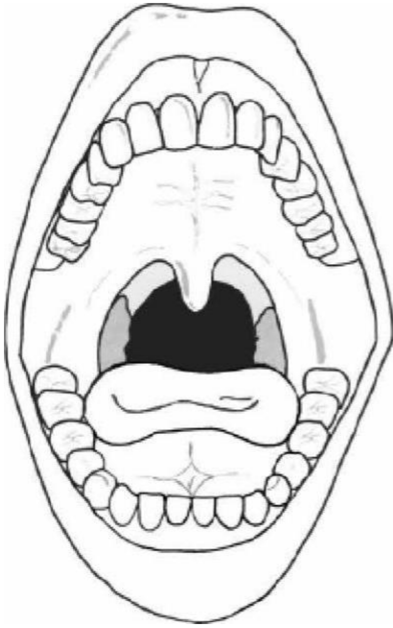
____

Does it tend to be worse at any time during the day/week/month? For example... (around menses, on awakening, weekends):____

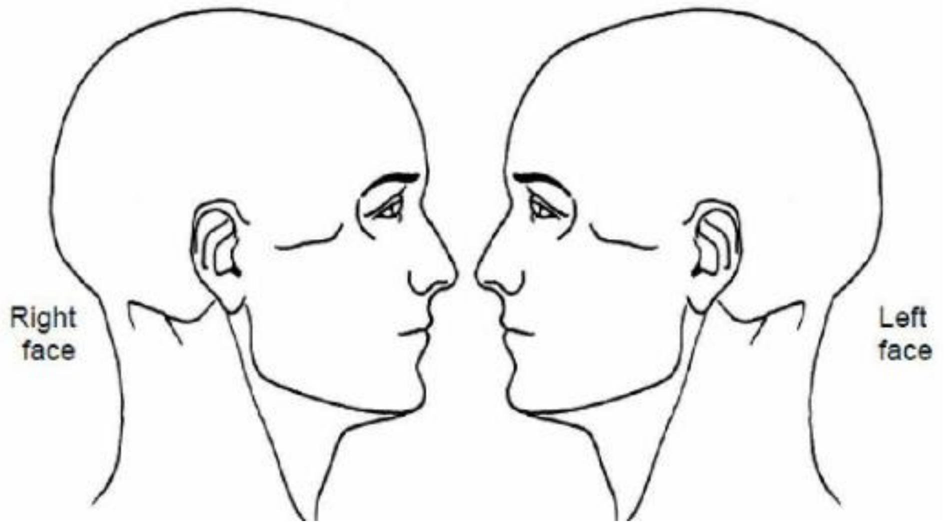
How many days per week are you usually pain free?____

LOCATION
PAIN DRAWING

Indicate the location of ALL of your different pains by SHADING in the area. If there is an EXACT SPOT, indicate with a SOLID DOT. If your pain MOVES FROM ONE LOCATION TO ANOTHER use ARROWS to show the path.



Mouth/Teeth



List ALL of your pain problems (worst pain first then add others in decreaseing order of severity):

1.____________________________

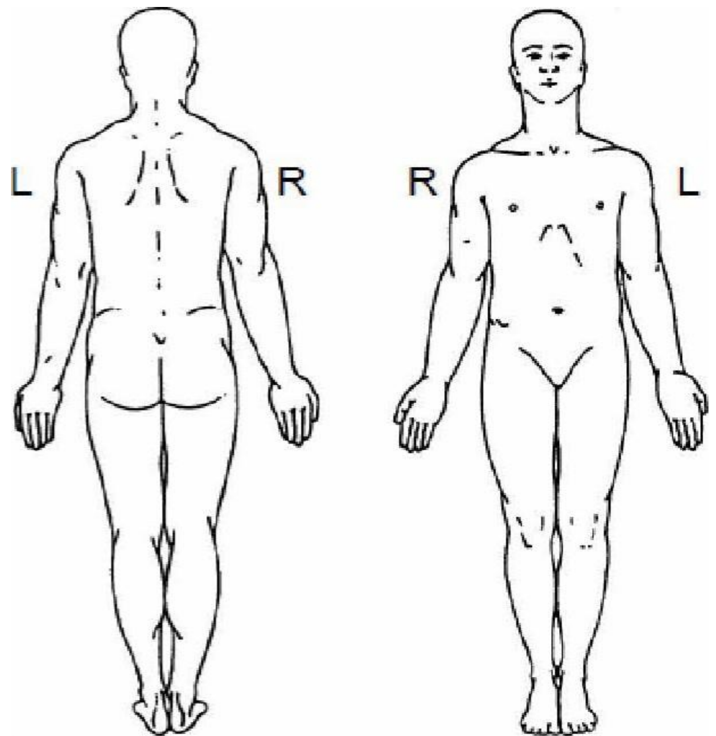
2.____________________________

3.____________________________

4.____________________________

5.____________________________

Which occurred first?



MODIFIERS:

If your pain comes and goes, what starts it?____

What makes it better?____

What makes it worse?____

Does anything else happen when your pain is present (swelling, change in vision, nausea, etc.)?____

What do you think is wrong and what do you think needs to be done?________________________

MEDICAL HISTORY

Medical Conditions (diagnoses):____

Current prescription medications:____

Current non-prescription medications:____________________ Allergies:____________________

Supplements and Vitamins:____

History of hospitalizations?____

Rate your overall health: great fair poor Rate your energy/drive: great fair poor

History of injury or trauma? Yes No____

Have you ever had a traumatic brain injury (TBI) or a concussion? Yes No

If yes, when?__________ how did it occur?____

Family Medical History: Siblings____

Father_______________________________ Mother_______________________________

PERSONAL

Weight:_________ Height:_________ Recent weight change? Y N Describe_______________________

Occupation:_________________________________

Tobacco: Y N Describe frequency and amount:__________________________________

Alcohol: Y N Describe frequency and amount:__________________________________

Caffeine: Y N Describe frequency and amount:__________________________________

Recreational drugs: Y N Describe frequency and amount:___________________________

NUTRITION: Rate the quality of your diet/nutrition: excellent good fair poor

Describe your diet:____

EXERCISE: Rate the quality/quantity your exercise: excellent good fair poor

Describe your weekly exercise routine: ____

HABITS:

Do you clench your teeth? Yes No Don't know

Do you grind your teeth? Yes No Don't know

Describe other habits or routines you think could influence your situation:____________________________

PSYCHOLOGY

Please rate your levels of:

	None	Worst possible
Stress	0____	10
Anger	0____	10

PHQ-4				
Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

In your lifetime, have you ever had any experience that was so frightening, horrible, or upsetting, that in the past month, you. . .

1. Had nightmares about it or thought about it when you did not want to? Y N
2. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? Y N
3. Were constantly on guard, watchful, or easily startled? Y N
4. Felt numb or detached from others, activities, or your surroundings? Y N

Have you ever thought of suicide or harming yourself? Yes No

HEADACHES

Do you have problems with headaches? Yes No For how long?______________________________________

Do you have more than one kind of headache? Yes No

Describe each type of headace you experience

	#1	#2	#3
Location			
Intensity Mild Moderate Severe			
Frequency (daily, weekly, monthly)			
When do they occur?			
How long do they last? (secs, mins, hours, days)			
What starts it? (triggers)			

With your headache, do you experience? nausea vomiting light sensitivity sound sensitivity
None of these dizziness aura(altered sensations) other _______________

JAWS TEETH EARS

Ear problems? Yes No fullness stuffiness ringing pain other_______________________________

Tooth pain? Yes No Describe____

Jaw/TMJ locking or catching? Yes No Describe____
Changes in how your bite feels? Yes No Describe____
Altered jaw movement(s)? Yes No Describe____

Jaw joint (TMJ) sounds? Yes No popping clicking grating/grinding other
Have there been any changes in the jaw sounds? Y N Describe___________________________________

SLEEP

Circle the words that best describe your sleep? Sound Good Fair Poor Light Restless
Do you consider your sleep to be restful or restorative? Yes No
Do you have a regular/consistent sleep schedule? Y N If no, describe ______________________________
Have you ever had a sleep study? Yes No Dates:____________________Results:____________________
Any witnessed: snoring gasping bruxing/grinding teeth chocking

Do you sleep using a CPAP &/or an oral device for sleep apnea? Yes No
Describe (most nights, every night, entire night?): ____

What are your usual sleep positions? side back stomach

Please cheek the most appropriate box concerning your SLEEP during the last 4 weeks.

	Not in last 4 weeks	Yes, 1 or 2 times a week	Yes, 3 or 4 times a week	Yes, 5 or more times a week
Trouble falling asleep				
Wake up several times a night?				
Wake up earlier than planned?				
Trouble getting back to sleep after you woke up too early?				

Please list any additional information that you feel is important for us to know about you, your complaint or other aspects of your visit.

____

____

____

____

LASTLY,

Do you anticipate filing for disability benefits concerning your symptoms? Yes No

Are you considering taking legal action regarding your problem? Yes No

Are attorneys already involved? Yes No

Please list your health providers below. Include their specialty and contact information.

______________________________________ ______________

Signature of Patient or Guardian Date