

HEAD, NECK, TMJ, & FACIAL PAIN OR DYSFUNCTION
SCREENING QUESTIONNAIRE

(Please Print with Blue Ballpoint)

Name: _____ Date: _____

Referred By: _____ Current Dentist: _____

1. One or more of the following symptoms may indicate a TMJ-Craniomandibular problem. If you have any of the following symptoms, please indicate by circling the appropriate descriptions around the drawing below.

(R: Right Side; L: Left Side)

HEAD

- 1. Tension Headaches R L
- 2. Migraines R L
- 3. Chronic Headaches R L
- 4. Tender to Touch R L

EAR

- 1. Clogged R L
- 2. Ear Pain R L
- 3. Ringing, Buzzing R L
- 4. Dizziness R L

JAW

- 1. Clicks, Pops R L
- 2. Joint Pain R L
- 3. Grinding Noise R L
- 4. Facial Pain R L



NASAL

- 1. Sinus Pain
- 2. Post Nasal Drainage
- 3. Allergic Conditions

EYE

- 1. Red Eyes R L
- 2. Light Sensitive R L
- 3. Pain Behind Eyes R L
- 4. Tears in Eyes R L

MOUTH

- 1. Abnormal Opening
- 2. Bad Bite
- 3. Missing Jaw Teeth
- 4. Excessive Mouth Breathing
- 5. Grind/Clench on Teeth

NECK & SHOULDERS

- 1. Pain R L
- 2. Stiffness R L
- 3. Poor Posture _____
- 4. Swallowing Difficulties _____

2. If you routinely have any pain, mark in red on the drawing in which area of the head or neck this pain occurs.

3. How long has this been a problem for you? _____

4. Does this condition alter the quality of your life? _____

5. Do you feel that you need more information about TMJ Disorders? _____

6. Do you feel that the doctor should examine you further concerning this condition? _____

Name _____ Date _____

Robert A. Finkel, D.D. S.
TMJ/ Orofacial Pain Narrative History

On behalf of my staff and myself, I welcome you into our fine family of patients. One of the most important elements in our diagnosis and treatment is the documentation process. This information gathering process is essential to our getting to know you and our better understanding of the pain you have been suffering. We know this is time-consuming; we thank you for your co-operation, as it critical to successful treatment.

The Documentation will consist of a narrative of your present dilemma, and a "Treatment History" in which you will be asked to describe, in as great a detail as you can remember, the complete account of your difficulties.

1. Please put the account in chronological order starting with the first symptoms you experienced, the first physicians or dentists you visited for the problem, the first treatment and the results (good or bad).
2. Be sure to list facial and bodily areas where you experienced pain or any other abnormal sensations.
3. List any physicians, dentists, ear-nose-throat specialists, orthopedists, chiropractors, or clinical teams who have treated you. Briefly describe their diagnosis and treatment. Use additional pages as necessary.
4. List the medications you are now taking and have taken in the past for this condition. On a separate line, list the medicines you take for other conditions, if any, and describe those conditions.
5. Finally, please share with me the importance of your getting well. What is your sense of commitment in getting the results you desire? How much do you expect us to supply a magic answer, and how committed are you to making lifestyle changes for your own benefit?

If time permits, please mail or drop off your report to me **before** your next appointment with us.

Thanks for letting us help!

Dr. Bob Finkel

Name _____ Date _____ Date of Birth _____

NARRATIVE

INFORMED CONSENT AGREEMENT

Temporomandibular Joint and Myofascial Pain can mimic other dental and medical problems. The diagnosis is very important because some of the medical problems that have similar headache or neckache symptoms can be life threatening: for example, intracranial tumor or coronary heart disease. You can help by giving the doctor a detailed medical and family history including a history of any food or drug allergies. Treatment for TM Joint/ Myofascial disorders can be lengthy and frustrating. You must inform the doctor about changes in jaw function; the best therapeutic improvement is a result of good patient-doctor communication. Please call our office anytime there is a problem or question about treatment.

Length of Treatment: Treatment time can vary widely. In general, the treatment plan will be more lengthy and complicated if the symptoms are severe, or if the problem has existed for a long time. Mild clicking with occasional muscle spasm headache may be successfully treated within a few weeks or months, but a long-standing arthritic joint disorder may require surgery, dental prosthetics, orthodontics, and/ or extensive restorative treatment procedures.

Possible Complications: We will make our best effort to diagnose and treat any TM Joint disorder with timely and cost-effective methods. The most proven and conservative techniques will be used. However, you should be aware that there is much debate in the scientific literature on the most effective techniques and/or combination of treatment modalities. These include, but are not limited to, prosthetic splints, restorative and prosthetic dental procedures, surgical dental procedures, TM Joint surgery, biofeedback, phonophoresis, iontophoresis, transcutaneous electrical nerve stimulation (TENS), minimal electroneural stimulation (MENS), acupuncture, muscle trigger-point injections, hypnosis, psychological counseling, orthodontic and orthopedic appliances. Orthodontic, orthopedic, and prosthetic appliances may be swallowed and may have to be surgically removed. Inhaled appliances can lead to respiratory arrest and death. These occurrences are extremely rare and any appliances used will be designed to minimize this possibility.

Some TM Joint symptoms may temporarily become worse with treatment. Patients with long-standing arthritic joint disease or traumatic injury can demonstrate more severe symptoms during the initial stages of treatment.

Unusual Occurrences: As with any form of medical or dental treatment, unusual occurrences can and do happen. Broken or loosened teeth, dislodged dental restorations, mouth sores, periodontal problems, root resorption, non-vital teeth, muscle spasms, ear and back problems, and numbness are all possible occurrences.

INFORMED CONSENT AGREEMENT (cont)

Most of these complications and unusual occurrences are infrequent. Additional medical and dental risks that have not been mentioned may occur. Good communication is essential for the best treatment results. Please call or come to the office if you have any questions or problems regarding treatment.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

I hereby agree to pay Dr. Robert A. Finkel such sums as may be due and owing him for professional services rendered in the treatment of my injury or illness. I fully understand that I am directly and fully responsible to the doctor for all medical bills submitted by him for services rendered to me, and that this agreement is made solely for the doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent upon any settlement, judgement or verdict by which I may eventually recover such a fee (In cases of accident, injury, or legal action). I understand that payment for all medical charges is my personal responsibility as my insurance company may disallow coverage for these disorders.

In the event this treatment is for illness arising from an accident or injury with attendant litigation, and there is any outstanding balance for treatment fees, I further agree that Dr. Finkel will be paid at the time of settlement, judgment, or verdict which may be paid to me or my attorney as a result of the above-mentioned injuries. I understand and agree that this in no way relieves me of any personal responsibility to pay Dr. Finkel for all medical charges.

In the event these charges are being submitted for payment to my medical, dental, or other insurance carrier, I am aware that each insurance carrier has its own policy regarding payment for TMJ/ Myofascial Pain Therapies and my insurance policy may not cover these medical charges. I am aware it is likely that my insurance company may disallow coverage for any or all of these charges and that I agree to be responsible for payment of them.

I understand that this office submits medical and dental charges to the appropriate insurance companies as a courtesy to me and that this does not relieve me of my responsibility for their payment. If/when such payment is declined by my insurance company, I will be responsible for payment; if not received from insurance company within 60 days.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

Name _____ Date _____

INFORMED CONSENT AGREEMENT (cont)

I, Undersigned (Patient or Legally Responsible Party), have read or have had read to me the contents of this form and do realize the risks and limitations involved and do authorize treatment to be rendered, and assume financial responsibility. It is also understood that any and all records, appliances, models, radiographs, video tapes, and photographs taken before, during, and after the examination and treatment shall remain the property of Robert A. Finkel, D.D.S., P.C.

Signature: _____ Date: _____

Witness: _____ Date: _____

I authorize Dr. Robert A. Finkel and Staff to furnish my attorney with such information, documents, and reports as he may request regarding my treatment.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

I authorize Dr. Robert A. Finkel and Staff to furnish my insurance company (ies) with such information, copies of documents, duplicates of x-rays and reports as it may request regarding my treatment. I understand that a reasonable fee may be charged for such reports and that all records, charts, models, and x-rays remain the property of Robert A. Finkel, D.D.S., P.C.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Name _____

Date _____

Robert A. Finkel, D. D. S.
TMJ and Orfacial Pain Patient Questionnaire

Please Print with Blue Ball Point

Sex _____ Date of Birth _____ Age _____

Marital Status _____ Height _____ Weight _____

Address _____

Phone _____ Social Security No. _____

Occupation _____ Employer _____

Business Phone _____

Employer Address _____

Who may we thank for referring you? _____

Address: _____

Dental Insurance Carrier: _____

Policy # _____ Name of Insured _____

Medical Insurance Carrier: _____

Policy # _____ Name of Insured _____

Automobile Insurance Carrier: _____

Policy # _____ Name of Insured _____

Auto Accident: Y N Claim # _____

Name of insured: _____ Date of Birth: _____

Address of Insured: _____

Name of Adjuster: _____

Insurance Notes:

Spouse's Name _____ Age _____ SS No. _____

Occupation _____ Employer _____

Employer Address _____

Phone _____

In case of emergency notify _____ Phone _____

Nearest relative not living with you _____

Address _____

Phone _____

Personal Physician _____ Phone _____

Address _____

Date of Last Exam _____

Personal Dentist _____ Phone _____

Address _____

Date of Last Exam _____

Name _____ Date _____

Nature of Problem (s):

Most Significant: _____

Next Significant: _____

Next Significant: _____

Date of onset _____ Area of Onset _____

Did Symptoms follow any physical or emotional occurrences? _____

What specialists have you seen for your pain?

Specialist Name/ Address	Dates Examined	Treatments	Results
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

What medications have you taken for your condition?

What medications are you now taking for your condition?

What treatment/medication was most successful? _____

What treatment/medication was least successful? _____

Are you aware of anything that aggravates your condition?
(stress, foods, alcohol, chewing, weather, etc.) _____

Are you aware of anything that helps relieve your pain? _____

How does your condition affect you? _____

Please circle the number which indicates severity of your pain:
No Pain-1-2-3-4-5-6-7-8-9-10- Severe Pain

Are you currently involved in or contemplating litigation related to your condition? YES NO

Name _____ Date _____

Have you ever had?

Trauma to the head, neck or face? YES NO If yes, please explain:

Are you being treated for any medical condition(s)? YES NO

If yes, please explain and list physician treating condition:

Are you now taking any medications? YES NO If yes, please explain:

Aspirin Y N _____

Oral Contraceptives Y N _____

Antibiotics Y N _____

Other _____

Other _____

Other _____

Are you allergic to any drugs? YES NO If yes, please explain:

Local Anesthetic _____

Antibiotics _____

Pain Killers _____

Other _____

Other _____

Date and reason for last physical exam: _____

Has your health changed in the last year? YES NO If yes, please explain:

Name _____

Date _____

Current or Previous Medical Problem(s):

(Please circle correct answer and give date of last occurrence.)

	Date		Date
Temporal Arteritis	Y N _____	Arthritis/Rheumatism	Y N _____
Stroke	Y N _____	Back/ Spinal Problems	Y N _____
Dizziness/ Fainting	Y N _____	Neck Problems	Y N _____
Seizures/ Epilepsy	Y N _____	Back/ Spine/ Neck Trauma	Y N _____
Migraines	Y N _____	Whiplash Injury	Y N _____
Extreme Mood Changes	Y N _____	Stomach Problems	Y N _____
Insomnia	Y N _____	Ulcers	Y N _____
Fatigability	Y N _____	Intestinal Problems	Y N _____
Sinus Infections	Y N _____	Medication Allergies	Y N _____
Tension Headaches	Y N _____	Allergies	Y N _____
Heart Murmur/ Defect	Y N _____	Hepatitis/ Liver Disease	Y N _____
Heart Trouble/ Attack	Y N _____	Jaundice/ Cirrhosis	Y N _____
Heart Surgery/ Pacemaker	Y N _____	Gall Bladder Problems	Y N _____
High Blood Pressure (Hypertension)	Y N _____	Use of Tobacco	Y N _____
Angina/ Chest Pain	Y N _____	Use of Alcohol	Y N _____
Shortness of Breath	Y N _____	Radiation Exposure	Y N _____
Low Blood Pressure (Hypotension)	Y N _____	Diabetes	Y N _____
Vascular Problems	Y N _____	Kidney/ Bladder Problems	Y N _____
Lung Disease	Y N _____	Venereal Disease	Y N _____
Hay Fever	Y N _____	Abnormal Bleeding/ Poor Clotting	Y N _____
Bronchial Asthma	Y N _____	Poor/ Delayed Healing	Y N _____
Skin/ Rash Disorders	Y N _____	Leukemia	Y N _____
Tachycardia (Rapid Heart)	Y N _____	Drug Dependency	Y N _____
Rheumatic Fever	Y N _____	AIDS/ A.R.C.	Y N _____
Mitral Value Prolapse	Y N _____	Infectious Condition	Y N _____
Stroke	Y N _____	Endocrine Problems	Y N _____
Cancer/ Tumors	Y N _____	Multiple Sclerosis	Y N _____
Radiation Therapy	Y N _____	Anemia	Y N _____
Tuberculosis	Y N _____	Other Blood Problems	Y N _____
Nervous/ Psychiatric Problems	Y N _____	Goiter/ Thyroid Disorder	Y N _____
Major Operations	Y N _____	Special Diets	Y N _____
Women: Pregnant	Y N _____	Eye, Ear, Nose, and Throat Problems	Y N _____
Menstrual Problems	Y N _____	Sleep Disorders	Y N _____
PMS	Y N _____	TMJ Problems	Y N _____
		Whiplash	Y N _____
		Muscle Problems	Y N _____

Please explain medical problem(s): _____

Any condition not mentioned? YES NO If yes, please explain: _____

Name _____

Date _____

Do You Have:

Difficulty in swallowing? Y N _____

Soreness around face or neck? Y N _____

Stiff neck muscles? Y N _____

Grinding or clenching of teeth during the day? Y N _____

Grinding or clenching of teeth during the night? Y N _____

Popping or clicking in right jaw joint? Y N _____

Popping or clicking in left jaw joint? Y N _____

Difficulty in opening wide? Y N _____

Stiff jaw or sore teeth upon waking? Y N _____

Stiff jaw or sore teeth at end of day? Y N _____

Headaches? Y N _____

Easily tired jaw muscles? Y N _____

ringing or buzzing in the ears? Y N _____

Pain on turning the head or moving the neck? Y N _____

Increased pain when reaching overhead? Y N _____

Numbness or tingling in hand and/or arm? Y N _____

Pain in hand and/or arm? Y N _____

Diet:

Do you have unusual reactions to any foods? Y N _____

Do any foods aggravate your condition? Y N _____

Do chewy foods (eg. Bagels) aggravate your condition? Y N _____

How many glasses of liquid do you drink daily? Y N _____

How many caffeine-containing drinks (coffee, tea, colas, etc.) do you consume daily? _____

What sugar-containing foods or drinks do you consume regularly? _____

Do you usually eat breakfast? _____

Sleep:

Do you awake with a morning headache? Y N _____

Do you have difficulty waking or feel drowsy during the morning? Y N _____

Do you feel fatigued through-out the day? Y N _____

Have you been told that you snore? Y N _____

Have you been told that you stop breathing and gasp for air while sleeping? Y N _____

Do you wake periodically during the night? Y N _____

Ear/Eye Symptoms:

R	L	NO		R	L	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in ear (Otalgia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo (dizziness, lost balance)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ear (Tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness/ Fullness in ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision changes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in hearing				

Describe your pain (underline all that apply)

Y N A. Stabbing/Sharp (Tissue) _____

Y N B. Shocking/ Piercing/Burning (Neural) _____

Y N C. Dull/ Aching (Myalgia/ Arthralgia) _____

Y N D. Spasming/ Tightening/ Cramping (Muscle) _____

Y N E. Pulsating (Vascular) _____

Y N F. Other _____

Frequency of Pain: (How Often?) _____

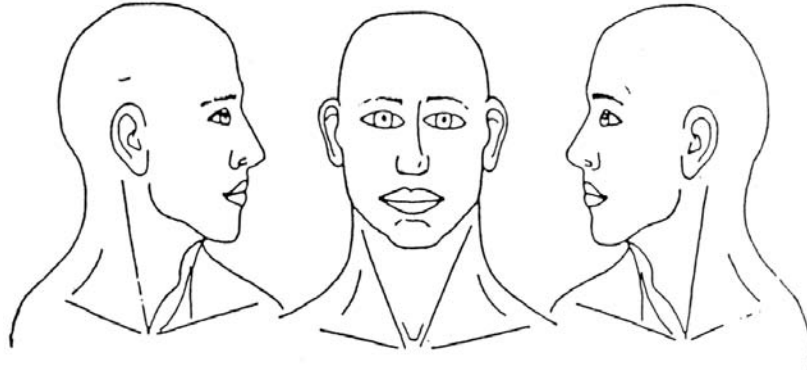
Onset of Pain: Gradual Abrupt _____

Duration of Pain: Gradual Abrupt _____

Cessation of Pain: Gradual Abrupt _____

Location of Pain (Subjective) (Grade 1-10) Please Shade in Red

- R L NO
- — Top of Head
- — Back of Head
- — Side of Head
- — In Ears
- — Front of Ears
- — In Eyes
- — Above Eyes
- — Behind Eyes
- — Neck
- — Shoulder/ Arm
- — Back
- — Teeth



Daily Pattern of Pain: If yes, please explain:

Severe upon waking? Y N _____

Severe at nights? Y N _____

Increases as day goes on? Y N _____

Decreases as day goes on? Y N _____

Period of greatest intensity? _____

Status of pain: Increasing Decreasing Unchanged _____

Daily Habits:

Phone Cradling Pipe/ cigar/ cigarette Gum Chewing

Shoulder Bag Heavy lifting Computer Use

Oral Habits:

Clenching: Nightly Daily None _____

Grinding: Nightly Daily None _____

Chewing/ Holding Items in Mouth: Y N _____

Chewing Gum or Tobacco: Y N _____

Have you had sinus infections/ problems? Y N _____

Do you have a sinus infection/ problem now? Y N _____

Do you play any musical instruments? Y N _____

Do any areas become painful with light touch? Y N _____

Do any areas become painful upon swallowing? Y N _____

Were you ever treated for a "bad bite"? Y N _____

Has your bite changed in the last five years? Y N _____

Have your jaw joints changed in the last five years? Y N _____

(popping, clicking, locking, pain?)

Have your teeth changed in the last five years? Y N _____

(thinner, breaking, chipping, shorter, looser, more spacing?)

Anything Else? Y N _____

Please explain: _____