CRANIOFACIAL PAIN QUESTIONNAIRE

This questionnaire was designed to provide important information regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take time to answer each question as completely and honestly as possible.

PATIENT INFORMATION

☐ MR. ☐ MRS. ☐ MISS ☐ MS. ☐ DR. Today's Date:_____

NAME:_____
FIRST MIDDLE INITIAL LAST

ADDRESS:_____ CITY/STATE/ZIP:_____

HOME PHONE:_____ BUSINESS PHONE:_____ ☐ MALE ☐ FEMALE

CELL PHONE: _____ EMAIL ADDRESS: _____

SOCIAL SECURITY NUMBER: _____-____-_____ DATE OF BIRTH: ____/____/____ AGE:_____

RESPONSIBLE PARTY:_____ PHONE:_____

ADDRESS:_____ CITY/STATE/ZIP:_____

EMPLOYER:_____ ADDRESS:_____

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____
POLICY HOLDER: _____ POLICY HOLDER: _____
POLICY HOLDER DOB: _____ POLICY HOLDER DOB: _____

☐ Please check box if you are pregnant or think you might be, and let our office know.

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most important, #2 being the next important, etc.

____ Back pain
____ Dizziness
____ Ear Congestion
____ Ear Pain
____ Eye Pain
____ Facial Pain
____ Fatigue
____ Headaches
____ Jaw Joint Noises
____ Jaw Locking
____ Jaw Pain

_____ Frequent heavy snoring
_____ Snoring that affects the sleep of others
_____ Sleep apnea
_____ CPAP intolerance
_____ Significant daytime drowsiness
_____ Difficulty falling asleep
_____ Gasping when waking up
_____ Nighttime choking spells
_____ Swelling in ankles or feet

_____ I have been told that "I stop breathing" when sleeping
_____ Feeling un-refreshed in the morning
_____ Morning hoarseness
_____ Morning headaches
_____ Nocturnal teeth grinding
_____ Limited Mouth Opening

____ Muscle Twitching
____ Neck Pain
____ Pain when Chewing
____ Ringing in the Ears
____ Shoulder Pain
____ Sinus Congestion
____ Throat Pain
____ Visual Disturbances

Write in any other symptoms:
____ _____
____ _____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED YOU TO HAVE AN ALLERGIC REACTION:

_____
_____
_____

REFERRED BY: _____

_____ ( )_____

ADDRESS CITY STATE ZIP PHONE NUMBER

FAMILY DENTIST:_____

_____ ( )_____

ADDRESS CITY STATE ZIP PHONE NUMBER

FAMILY PHYSICIAN:_____

_____ ( )_____

ADDRESS CITY STATE ZIP PHONE NUMBER

PLEASE LIST ALL TREATMENTS AND HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING OR HAVE SEEN FOR THIS PROBLEM:

Practitioner:_____MD/DDS Specialty:_____

_____ ( )_____

ADDRESS CITY STATE ZIP PHONE NUMBER

Diagnosis/Treatment: _____ Dates of Treatment:_____

Practitioner:_____MD/DDS Specialty:_____

_____ ( )_____

ADDRESS CITY STATE ZIP PHONE NUMBER

Diagnosis/Treatment: _____ Dates of Treatment:_____

Which of the following have you tried to help your pain/condition? On a scale of 1-5, please rate how effective each was in relieving your symptoms (1-not effective, 2-slightly effective, 3-moderately effective, 4-very effective, 5-most effective)

□Wearing night guard	1 2 3 4 5	□Massage	1 2 3 4 5	Medications (including Advil, etc)	
□Stretching exercises	1 2 3 4 5	□Relaxation techniques	1 2 3 4 5	_____	1 2 3 4 5
□Ice/moist heat	1 2 3 4 5	□Biofeedback	1 2 3 4 5	_____	1 2 3 4 5
□Physical therapy	1 2 3 4 5	□ Pain management	1 2 3 4 5	□Other:	
				_____	1 2 3 4 5

WHEN DID YOUR CONDITION FIRST OCCUR? _____

WHAT DO YOU BELIEVE IS THE CAUSE OF YOUR PAIN OR CONDITION?_____

		DATE	*DESCRIPTION OF INJURY*
_____	Motor Vehicle Injury	___/___/___	_____
_____	Worker's Compensation Injury	___/___/___	_____
_____	Accidental Injury	___/___/___	_____
_____	Disease/Injury	___/___/___	_____
_____	Unknown Cause	___/___/___	_____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN (including over the counter medications, vitamins, and supplements) AND THE REASON FOR TAKING THE MEDICATION:

_____

_____

_____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN (including over the counter medications, vitamins, and supplements) AND REASON FOR TAKING THE MEDICATION:

_____

_____

_____

_____

_____

MEDICAL HISTORY

Y☐ N☐ Adenoids removed
Y☐ N☐ Tonsils removed
Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Chronic sinus problems
Y☐ N☐ Chronic fatigue
Y☐ N☐ Congestive heart failure
Y☐ N☐ Current pregnancy
Y☐ N☐ Depression
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Fibromyalgia
Y☐ N☐ Frequent cough
Y☐ N☐ Frequent sore throat
Y☐ N☐ Gastroesophageal Reflux Disease (GERD)
Y☐ N☐ Hay fever
Y☐ N☐ Heart disorder
Y☐ N☐ Heart murmur
Y☐ N☐ Heart pounding or beating Irregularly during the night
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart palpitations
Y☐ N☐ Heart valve replacement
Y☐ N☐ Heartburn or a sour taste in the mouth at night
Y☐ N☐ Hepatitis
Y☐ N☐ High blood pressure
Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to face
Y☐ N☐ Injury to mouth
Y☐ N☐ Injury to neck
Y☐ N☐ Injury to teeth
Y☐ N☐ Irregular heart beat
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Low blood pressure
Y☐ N☐ Memory loss
Y☐ N☐ Migraines
Y☐ N☐ Morning dry mouth
Y☐ N☐ Muscle spasms or cramps
Y☐ N☐ Muscular dystrophy
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Nervous system irritability
Y☐ N☐ Nighttime sweating
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Recent excessive weight gain
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Shortness of breath
Y☐ N☐ Swollen, stiff, or painful joints
Y☐ N☐ TMJ disorder
Y☐ N☐ Thyroid problems
Y☐ N☐ Wisdom teeth extraction

Y☐ N☐ Other medical/dental history _____

_____

_____

_____

Patient Name _____ Date _____

Patient Name _____ Date _____

FAMILY HISTORY

Do you have a loved one that has been diagnosed with obstructive sleep apnea and is not currently being treated? Y☐ N☐

Do you have a loved one you think might have undiagnosed sleep apnea? Y☐ N☐

Have any members of your family (blood kin) had:

Y☐ N☐ Heart disease
Y☐ N☐ High blood pressure
Y☐ N☐ Diabetes

SLEEP CENTER EVALUATION

Have you ever had an evaluation at a Sleep Center? Y ☐ N ☐

Sleep Center Name _____Location_____ Date of Study _____

CPAP (Continuous Positive Airway Pressure device)

Have you used CPAP? Y☐ N☐ For how long: _____

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to: (mark all that apply)

_____Mask leaks
_____I was unable to get the mask to fit properly
_____Discomfort caused by the strap or headgear
_____Disturbed or interrupted sleep caused by the presence of the device
_____Noise from the device disturbing my and/or bed partner's sleep
_____CPAP restricted movements during sleep
_____CPAP does not seem to be effective
_____Pressure on the upper lip causing tooth related problems
_____A latex allergy
_____Claustrophobic associations
_____An unconscious need to remove the CPAP apparatus at night
_____Other: _____

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders (weight loss, smoking cessation, surgery, etc.)?

_____

_____

Has any doctor recommended that you have surgery for this condition? Y☐ N☐

SOCIAL HISTORY

How often do you consume alcohol within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

How often do you take sedatives within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

How often do you consume caffeine within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

Do you smoke? Y ☐ N ☐ If YES, how many a day? _____

Do you use chewing tobacco? Y ☐ N ☐

Patient Name: _____ Height: _____ Weight: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

Situation	**Chance of Dozing**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theatre or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

		Yes	**No**	**Not Sure**
1.	Have you been told (or noticed on your own) that you snore most nights?	☐	☐	☐
2.	Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep, sometimes followed by a GASP?	☐	☐	☐
3.	Are you tired, fatigued or sleepy on most days?	☐	☐	☐
4.	Do you have acid indigestion or high blood pressure (or use medication to control either of these conditions)?	☐	☐	☐
5.	Are you overweight?	☐	☐	☐
6.	Have you ever been diagnosed with obstructive sleep apnea (OSA)?	☐	☐	☐
7.	Are you currently being treated for OSA?	☐	☐	☐
8.	Are you aware of family history of OSA?	☐	☐	☐
9.	Are you aware of clenching or grinding your teeth at night?	☐	☐	☐
10.	Do you snore loudly (louder than talking or loud enough to be heard behind a closed door)?	☐	☐	☐
11.	Do you often feel tired, fatigued or sleepy during daytime?	☐	☐	☐
12.	Has anyone observed you stop breathing during your sleep?	☐	☐	☐
13.	Do you have or are you being treated for high blood pressure?	☐	☐	☐
14.	Are you 50 years old or older?	☐	☐	☐
15.	Does your neck measure more than 15 ¾ inches (40cm) around?	☐	☐	☐
16.	Are you a male?	☐	☐	☐
17.	Do you weigh more for your height than is shown in the table below?	☐	☐	☐

Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)	Height	Weight (lb)
4’10”	167	5’3”	197	5’8”	230	6’1”	265
4’11”	173	5’4”	204	5’9”	237	6’2”	272
5’	179	5’5”	210	5’10”	243	6’3”	279
5’1”	185	5’6”	216	5’11”	250	6’4”	287
5’2”	191	5’7”	223	6’	258	6’5”	295
Weights shown in the tables above correspond to BMI of 35 for a given height.							

Insomnia Severity Index

Patient's Name _____ Date _____

For each question, make a single selection to check a box. Click the button to clear the form if needed.

Clear

1. Please rate the current (last 2 weeks) SEVERITY of your insomnia problem(s).

	None 0	*Mild* 1	*Moderate* 2	*Severe* 3	*Very* 4	Score
Difficulty falling asleep						0
Difficulty staying asleep						0
Problem waking up too early	☐	☐	☐	☐	☐	0

2. How SATISFIED/dissatisfied are you with your current sleep pattern?

Very Satisfied 0	*Satisfied* 1	*Somewhat Satisfied* 2	*Dissatisfied* 3	*Very Dissatisfied* 4	
☐	☐	☐	☐	☐	0

3. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)

Not at all Interfering 0	*A Little Interfering* 1	*Somewhat Interfering* 2	*Much Interfering* 3	*Very Much Interfering* 4	
☐	☐	☐	☐	☐	0

4. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable 0	*A Little Noticeable* 1	*Somewhat Noticeable* 2	*Much Noticeable* 3	*Very Much Noticeable* 4	
☐	☐	☐	☐	☐	0

5. How WORRIED/distressed are you about your current sleep problem?

Not at all Worried 0	*A Little Worried* 1	*Somewhat Worried* 2	*Much Worried* 3	*Very Much Worried* 4	
☐	☐	☐	☐	☐	0

Guidelines for Scoring/Interpretation:

The total score is the sum of all seven items**.** Total score ranges from 0-28.

0 - 7	No clinically significant insomnia
8 - 14	Subthreshold insomnia
15 - 21	Clinical insomnia (moderate severity)
22 - 28	Clinical insomnia (severe)

TOTAL Score

0