Alice Lam, D.D.S.

# Facial Pain Screening History

Date _____

Name _____ Age _____

Who have you seen (healthcare provider) for this condition?

_____

If treatment was done, did any make you feel better?

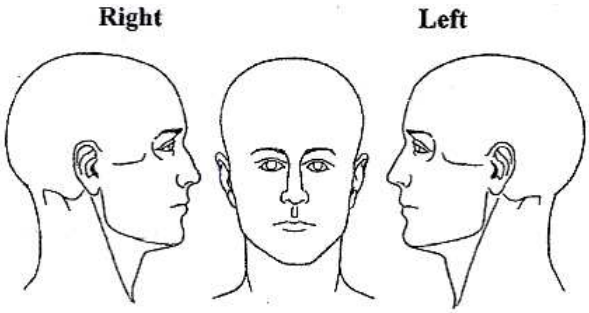
_____

Did any make you feel worse?

_____

Office use only

On the figures below, please outline where your pain is:




**Mark intensity of pain in appropriate areas:**

1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

*(Little pain)* *(Worst pain imaginable)*

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**TM Joint Dysfunction?**

Does your jaw pop or click when you open? ☐ Yes ☐ No With pain? ☐ Yes ☐ No

How often does this happen? _____

How long have you had this noise problem? _____

If your jaw has locked when did this first happen? _____

Last happen? _____ How often? _____ Which side? _____

Does your jaw ever get "struck"? ☐Yes ☐ No When does this happen? _____

_____

**If You Have Headaches?**

"Normal Headaches": Location: _____ Intensity: _____ (1-10) How often? _____

☐ Visual effects ☐ Light Sensitivity ☐ Sound Sensitivity ☐ Dizziness ☐ Nausea ☐ Neck

What medications do you take for <u>these</u> headaches? _____

Does anyone in your family get migraines? ☐ Yes ☐ No If yes, who? _____

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Do you have any of the following:

YES NO Loss of strength anywhere? _____

YES NO Wake up rested? _____

YES NO Trouble going to sleeping because of this condition? _____

How many nights per week? _____

YES NO Your condition wakes you. How many nights per week? _____

Are you depressed? ☐ Often ☐ Sometimes ☐ Never

Do you consider yourself? ☐Calm (laid back) ☐Moderate ☐Tense (uptight)

Do you have stress in your life? ☐ None ☐Some ☐ Enormous

Do you have thoughts of suicide? ☐ Never ☐ Sometimes ☐ Often

Do you sleep in the same room with someone who **snores**? ☐ Yes ☐No

If 'yes' does this disturb your sleep? ☐Yes ☐ No

What percentage of your pain relief do you expect with treatment? _____%

**What Does Your Pain Feel Like?**

**Some of the words below describe your present pain. Circle only those words that describe it. Leave out any category that is not suitable.**

1. Flickering
   Quivering
   Pulsing
   Throbbing
   Beating
   Pounding

2. Jumping
   Flashing
   Shooting

3. Pricking
   Boring
   Drilling
   Stabbing
   Lancinating

4. Sharp
   Cutting
   Lacerating

5. Pinching
   Pressing
   Gnawing
   Cramping
   Crushing

6. Tugging
   Pulling
   Wrenching

7. Hot
   Burning
   Scalding
   Searing

8. Tingling
   Itchy
   Smarting
   Stinging

9. Dull
   Sore
   Hurting
   Aching
   Heavy

10. Tender
    Taut
    Rasping
    Splitting

11. Tiring
    Exhausting

12. Sickening
    Suffocating

13. Fearful
    Frightful
    Terrifying

14. Punishing
    Grueling
    Cruel
    Vicious
    Killing

15. Wretched
    Blinding

16. Annoying
    Troublesome
    Miserable
    Intense
    Unbearable

17. Spreading
    Radiating
    Penetrating
    Piercing

18. Tight
    Numb
    Drawing
    Squeezing
    Tearing

19. Cool
    Cold
    Freezing

20. Nagging
    Nauseating
    Agonizing
    Torturing

**Patient Signature** _____ **Date** _____ *Office Use: Sensory ___ Affective ___ Evaluative ___ Total ___*