Date Completed: _____

OROFACIAL PAIN EVALUATION FORM

Name: _____
Last First

Age: _____ Right _____ Left _____ handed:

Height: _____ Weight: _____

I.. History of Your Pain

A. When did your pain start? _____

B. When did your pain become a problem? _____

C. How many times have you gone to the emergency room for pain in the past year? _____

D. What event or events led to your present pain:

- ☐ accident
- ☐ other injury
- ☐ other disease
- ☐ other _____
- ☐ cancer
- ☐ no obvious cause
- ☐ following an operation

Describe details of your injury or accident:

_____

_____

_____

_____

E. What do YOU think is the cause of your pain?

_____

_____

_____

II. Understanding Your Pain

A. Describe in *your own words* the pain problem you would like help with and *list* as follows: 1) **facial pain; 2) headache 3) tooth pain 4) other pain:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

B. How often does your *JAW PAIN* occur?

- ☐ continuous
- ☐ several times a day
- ☐ once per day
- ☐ once per week
- ☐ less than once per week
- ☐ never

C. What is the duration of your *JAW PAIN*?

- ☐ none
- ☐ seconds
- ☐ minutes
- ☐ hours
- ☐ days
- ☐ weeks
- ☐ continuous

D. Does your jaw lock or become stuck?
- ☐ Never
- ☐ Occassionally
- ☐ Daily

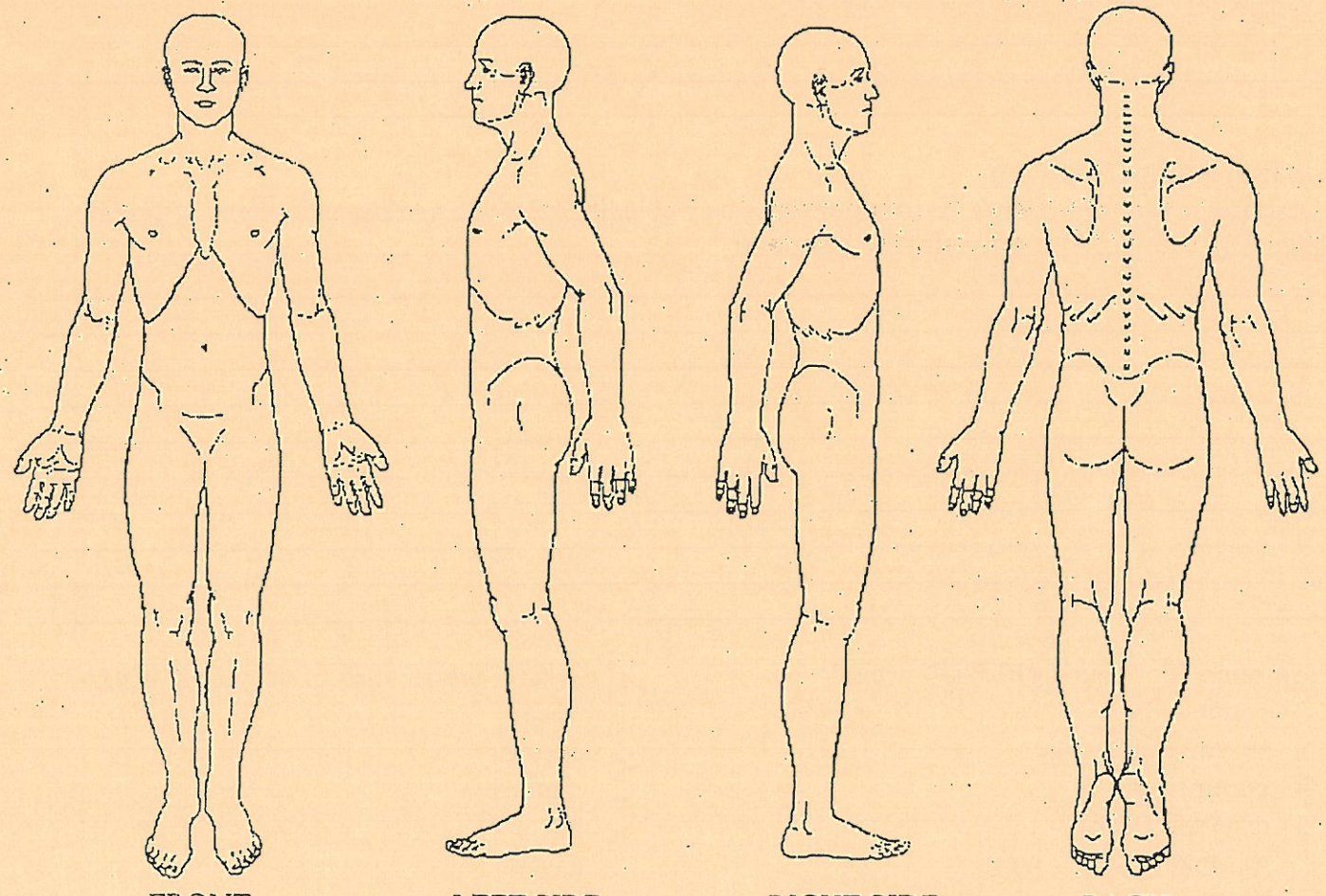
E. Does your jaw lock so that you are unable to **OPEN** or **CLOSE** your mouth ? (Circle one answer)

F. Please check all words that describe your **JAW PAIN**:
- ☐ Dull, Aching
- ☐ Gnawing
- ☐ Sharp
- ☐ Tiresome
- ☐ Throbbing
- ☐ Stabbing
- ☐ Electric shock
- ☐ Other _____

G. Circle the number to indicate the level of pain you are having *NOW* as well as your *WORST* pain.

0	1	2	3	4	5	6	7	8	9	10
None		Mild		Moderate			Severe			Completely

H. Please indicate where you have jaw pain or headaches :



FRONT LEFT SIDE RIGHT SIDE BACK

I. What makes the jaw pain *WORSE*? Be Specific. _____

_____

J. What makes the jaw pain *BETTER*? Be Specific. _____

_____

III. HEADACHES

A. How often do you get headaches?

- ☐ Never
- ☐ Daily
- ☐ _____ headaches per week
- ☐ _____ headaches per month
- ☐ Other _____

B. My headaches cause:

- ☐ Nausea
- ☐ Vomiting
- ☐ Sensitivity to bright lights
- ☐ Sensitivity to loud noise
- ☐ Visual changes (blurred vision, spots, wavy lines)

C. My headache pain is:

- __ Throbbing
- __ Aching
- __ Pressure
- __ Ice-pick like
- __ Other _____

D. My headaches last:

- ___ Minutes
- ___ Hours _____
- ___ Days _____

E. My headaches are located: _____

F. My headaches are triggered by: _____

IV. Effect of Pain on Your Activity

1. Circle the number to indicate how much your pain has interfered with your activities this **past week.**

0	1	2	3	4	5	6	7	8	9	10
None		Mild		Moderate			Severe			Completely

2. Circle the number to indicate how distressed or bothered you have been in the **past week** about the pain.

0	1	2	3	4	5	6	7	8	9	10
None		Mild		Moderate			Severe			Completely

V. Please list, in chronological order, all tests, xrays, MRI's,/CT scans performed to evaluate your pain:

Date	Test	Doctor Who Ordered The Test
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VI. Indicate which of the following treatments you have tried for your pain problem:

☐ antidepressants	☐ acupuncture	☐ psychotherapy	☐ homeopathy
☐ narcotics	☐ chiropractor	☐ biofeedback	☐ TENS
☐ nerve blocks	☐ massage	☐ relaxation training	☐ exercise program
☐ traction	☐ physical therapy	☐ hypnosis	

VII. List all *previous* pain medications you have taken for pain:

Name of medicine	Dose	Dates of use	Helpful?	Reason for stopping
_____	_____	_____	YES NO	_____
_____	_____	_____	YES NO	_____
_____	_____	_____	YES NO	_____
_____	_____	_____	YES NO	_____

VIII. Habits

A. Smoking: yes___ no___ quit ___ number of packs/day_____
Number of years smoke(d) _____

B. Alcohol Use: none ___ occasional___ daily ___ How much per week?_____

C. Recreational Drugs:
◊ cocaine ◊ amphetamines ◊ marijuana ◊ heroin ◊ other_____ ___

D. Caffeine (Coffee/Tea): Number of cups/day_____

E. Clenching teeth: yes___ no___ Grinding teeth: yes___ no___ Daytime ___ Nighttime ____

F. Is anyone concerned about your use of alcohol, drugs, or medications? YES NO

IX. Family History

Member	Deceased or Living	Age	Medical Problems
1. Father	_____	___	_____
2. Mother	_____	___	_____
3. Siblings	_____	___	_____
	_____	___	_____
	_____	___	_____
4. Spouse	_____	___	_____

X. Social History

A. Relationship Status:
☐ single ☐ separated
☐ significant other ☐ divorced
___ male ___ female
☐ married ☐ widowed

B. Highest level of education you have completed:
☐ less than high school ☐ college
☐ high school ☐ graduate
☐ vocational ☐ other_____

C. What is your current employment status?
☐ employed full time ☐ homemaker ☐ unemployed due to other reasons
☐ employed part time ☐ unemployed due to pain ☐ retired
☐ self-employed

D. Number of hours worked per week: _____ Are you happy with your job? _____
Your current or most recent occupation _____

XI. Psychological History

1. Describe your mood:_____

Do you have problems with any of the following:

- ☐ concentration
- ☐ motivation
- ☐ sleep
- ☐ anxiety
- ☐ depression
- ☐ self worth
- ☐ homicidal thoughts
- ☐ appetite
- ☐ suicidal thoughts

XII. Financial Information

A. What are your present sources of financial support?

- ☐ Personal earnings
- ☐ disability
- ☐ workman's comp
- ☐ spouse's earnings
- ☐ pension/retirement
- ☐ insurance
- ☐ other_____
- ☐ none

B. Are you hoping to receive other income or compensation? If so, please indicate:

- ☐ disability payment
- ☐ legal settlement
- ☐ workmen's compensation
- ☐ other (describe)_____

C. Do you have any legal action pending related to this pain or any other health problem? YES___ NO___

Revised January 6, 2002