TMJ

Head, Neck and Facial Pain Questionnaire

Please fill out form completely. Thank You

Date

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Short Hills, NJ 07078
973-921 -0771

PATIENT INFORMATION

Patient's Name		Phone Number Home Work Cell	
Street Address		City	State / Zip
Age / Date of Birth		Gender Male ☐ Female ☐ Other ☐	Who may we thank for referring you?
Family Physician		Family Dentist	
In Case of Emergency, Who Should be Notified?		Relationship/Phone	

PERSON RESPONSIBLE FOR ACCOUNT INFORMATION:

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ SS# _____

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

Work Phone _____

PRIMARY MEDICAL INSURANCE INFORMATION:*

Name of Insurance _____

Address _____

City _____ State _____ Zip _____

Name of Insured _____

Insured's Date of Birth _____

Insured's Employer _____

Policy/ID# _____ Effective Date _____

SECONDARY MEDICAL INSURANCE INFORMATION:*

Name of Insurance _____

Address _____

City _____ State _____ Zip _____

Name of Insured _____

Insured's Date of Birth _____

Insured's Employer _____

Policy/ID# _____

We do not participate with any medical insurance programs. Insurance information is for patient reimbursement purposes only.

Signature of Patient, Parent, or Guardian _____ Date _____

Signature of Insured _____ Date _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?
(Please order ***YOUR*** chief complaints by number, with "1" being most important)

_____ Back Pain	_____ Jaw Clicking	_____ Pain Behind Eyes
_____ Dizziness	_____ Jaw Joint Noises	_____ Pain When Chewing
_____ Ear Pain	_____ Jaw Locking	_____ Ringing in the Ears
_____ Ear/Sinus Congestion	_____ Jaw Pain	_____ Shoulder Pain
_____ Facial Pain	_____ Limited Mouth Opening	_____ Throat Pain
_____ Fatigue	_____ Muscle Twitching	_____ Tinnitis
_____ Headaches	_____ Neck Pain	_____ Visual Disturbances
_____ Inability To Open Mouth	Other _____	

LIST TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING

	Practitioner	Specialty	Treatment & Approx. Date
1.			
2.			
3.			
4.			

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ***ALLERGIC REACTION***

☐ Antibiotics	☐ Latex	☐ Plastic
☐ Aspirin	☐ Local Anesthetics	☐ Sedatives
☐ Barbiturates	☐ Metals	☐ Sleeping Pills
☐ Codeine	☐ Penicillian	☐ Sulfa Drugs
☐ Iodine	Other Allergans _____	

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

☐ Antibiotics	☐ Cortisone	☐ Nerve Pills
☐ Anticoagulants	☐ Diet Pills	☐ Pain Medication
☐ Barbiturates	☐ Heart Medication	☐ Sleeping Pills
☐ Blood Thinners	☐ Insulin	☐ Sulfa Drugs
☐ Codeine	☐ Muscle Relaxants	☐ Tranquilizers
Other _____		

ARE YOU PREGNANT? Yes ☐ No ☐	IF YES, HOW FAR ALONG?

THIS SPACE FOR OFFICE USE:

MEDICAL HISTORY

- ☐ Adenoids
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune Disorders
- ☐ Bleeding Easily
- ☐ Blood Pressure- High
- ☐ Blood Presure- Low
- ☐ Bruising Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chronic Fatigue
- ☐ Cold Hands/Feet
- ☐ Current Pregnancy
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Concentrating
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Thirst
- ☐ Fluid Retention
- ☐ Frequent Cough
- ☐ Frequent Illnesses
- ☐ Frequent Stressful Situations
- ☐ General Anesthesia
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay Fever
- ☐ Hearing Impairment

Other Medical/Dental History

- ☐ Heart Murmur
- ☐ Heart Disorder
- ☐ Heart Pacemaker
- ☐ Heart Palpitations
- ☐ Heart Valve Replacement
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hypoglycemia
- ☐ Immune System Disorder
- ☐ Injury to Face
- ☐ Injury to Mouth
- ☐ Injury to Neck
- ☐ Injury to Teeth
- ☐ Insomnia
- ☐ Intestinal Disorders
- ☐ Jaw Joint Surgery
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Meniere's Disease
- ☐ Menstrual Cramps
- ☐ Multiple Sclerosis
- ☐ Muscle Aches
- ☐ Muscle Shaking (Tremors)
- ☐ Muscle Spasms or Cramps
- ☐ Muscular Dystrophy
- ☐ Needing Extra Pillows to Help Breathing at Night
- ☐ Nervous System Irritability
- ☐ Nervousness
- ☐ Neuralgia

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Ovarian Cysts
- ☐ Parkinson's Disease
- ☐ Poor Circulation
- ☐ Prior Orthodontic Treatment
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Disorder
- ☐ Slow-Healing Sores
- ☐ Snoring
- ☐ Speech Difficulties
- ☐ Stroke
- ☐ Swollen, Stiff or Painful Joints

Tendency For:

- ☐ Ear Infections
- ☐ Frequent Colds
- ☐ Sore Throats
- ☐ Tired Muscles
- ☐ Tonsils Removed
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Urinary Disorders
- ☐ Wisdom Teeth (3rd Molar) Extraction
- ☐ Yeast Infections

SYMPTOMS

L=Left R= Right B= Both Sides

Head Pain

	Location	Severity			Frequency			Duration				
		MILD	MODERATE	SEVERE	OCCASIONAL	FREQUENT	CONSTANT	SECONDS	MINUTES	HOURS	DAYS	WEEKS
N/A	Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
N/A	Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
N/A	Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
N/A	Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
N/A	In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Jaw Pain

N/A Jaw pain- upon opening _____

N/A Jaw pain- while chewing _____

N/A Jaw pain- at rest _____

Jaw Symptoms

- ☐ Jaw clicks _____
- ☐ Jaw locks closed _____
- ☐ Jaw locks open _____
- ☐ Jaw popping _____
- ☐ Teeth clenching _____
- ☐ Teeth grinding _____

MEDICAL HISTORY (continued)

Eye-Related Conditions

N/A Blurred vision
N/A Double vision
N/A Eye pain
N/A Pain/Pressure behind eyes
N/A Photophobia (light sensitivity)

Ear Related Conditions

☐ Buzzing in the ears
☐ Ear congestion
☐ Ear pain
☐ Hearing loss
☐ Pain behind ear
☐ Pain in front of ear
☐ Recurent ear infections
☐ Tinnitus (ringing in the ear)

Throat, Neck & Back Related Conditions

☐ Back pain- upper
☐ Back pain- middle
☐ Back pain- lower
☐ Chronic sore throat
☐ Constant feeling of a foreign object in throat
☐ Difficulty swallowing
☐ Limited neck movement
☐ Neck pain
☐ Hand/finger numbness
☐ Other _____

☐ Sciatica
☐ Scoliosis
☐ Shoulder pain
☐ Shoulder stiffness
☐ Swelling in the neck
☐ Swollen glands
☐ Thyroid enlargement
☐ Tightness in throat
☐ Tingling hands/fingers
☐ Wryneck

Mouth & Nose Related Conditions

☐ Broken teeth
☐ Burning tongue
☐ Chronic sinusitis
☐ Dry mouth
☐ Frequent biting of cheek
☐ Frequent snoring

Lifestyle Related Conditions

☐ Currently under unusual stress
☐ Recent change in lifestyle
☐ Recent change in work pattern

Do you drink 2 or more alcoholic beverages per day? Yes ☐ No ☐	Substance Dependency? Yes ☐ No ☐ _____
Do you drink 4 or more cups of coffee per day? Yes ☐ No ☐	Do you smoke tobacco? Yes ☐ No ☐ _____
Does any family member have the same or similar problem? Yes ☐ No ☐	

If yes, please explain _____

What makes your discomfort/pain worse? _____

HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do you believe is the cause of your pain or condition? _____

☐ Athletic endeavor ☐ Fight ☐ Fall ☐ Accident ☐ Heredity ☐ Illness ☐ Injury
☐ Unknown ☐ If accident, date _____
☐ Other _____

What other information is important to your pain or condition?

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ E-mail: _____

Address: _____

Telephone: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available by request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kischa, Dr. Michael Messing LLC

Telephone: 973-921-0771

Address: 7 Short Hills Ave, Short Hills, NJ 07078

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out our treatment, payment activities and health care operations which may include email or texts.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.