Currently Experiencing

Are you currently experiencing head pain? ☐ yes ☐ no

If yes, please indicate all that apply:

	Location			Time Frame		Severity			Duration			Frequency		
	Left	Right	Bilateral	Recent	Chronic (over 6 mo.)	Mild	Moderate	Severe	Min.	Hrs.	Days	Occasional	Frequent	Constant
Temple Area (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Back of Head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Forehead (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Top of Head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
General Head Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are you currently experiencing jaw conditions? ☐ yes ☐ no

If yes, please indicate all that apply:

Jaw pain with opening	☐ left	☐ right
Jaw pain when chewing	☐ left	☐ right
Jaw pain at rest	☐ left	☐ right
Jaw sounds with opening	☐ left	☐ right
Jaw sounds when chewing	☐ left	☐ right
Jaw sounds at rest	☐ left	☐ right

Please indicate if you have had any of the following:

___Jaw Locks Closed
___Jaw Locks Open
___Daytime Teeth Clenching/Grinding
___Nighttime Clenching/Grinding
___Blurred Vision
___Double Vision
___Pain/Pressure behind eyes
___Extreme Sensitivity to light
___Wear Glasses or Contact Lenses

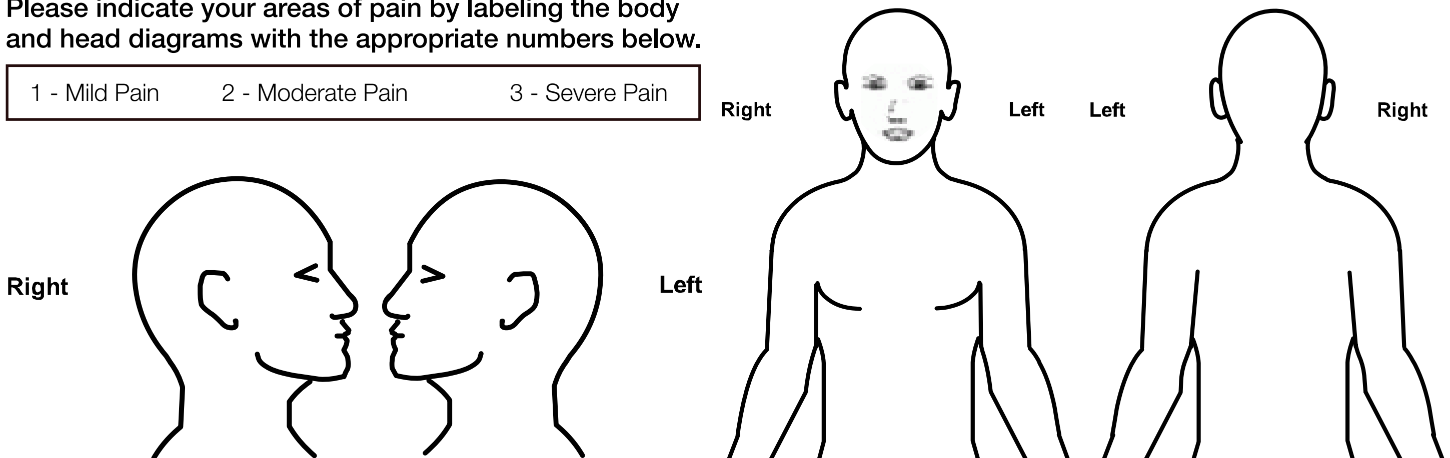
Are you currently experiencing any ear related conditions? ☐ yes ☐ no

If yes, please indicate all that apply:

Ear Congestion	☐ left	☐ right
Ear Pain	☐ left	☐ right
Hearing Loss	☐ left	☐ right
Itchiness or Stuffiness in Ears	☐ left	☐ right
Pain Behind the Ear	☐ left	☐ right
Pain in Front of the Ear	☐ left	☐ right
Recurrent Ear Infections	☐ left	☐ right
Ringing in the Ear	☐ left	☐ right

Please indicate your areas of pain by labeling the body and head diagrams with the appropriate numbers below.

1 - Mild Pain	2 - Moderate Pain	3 - Severe Pain



Patient Initials: ________

COLUMBIA CENTER for SLEEP APNEA & TMJ

Please indicate if you have had any of the following:

___Chronic Sore Throat
___Difficulty Swallowing
___Swollen Gland
___Thyroid Enlargement
___Tightness in Throat
___Constant Feeling of Foreign Object in Throat
___Limited Movement of Neck

___Neck Pain
___Numbness in hands/fingers
___Swelling in the neck
___Shoulder Pain
___Shoulder Stiffness
___Tingling in hands or fingers
___Lower Back Pain
___Upper Back Pain

___Middle Back Pain
___Scoliosis
___Sciatica
___Chronic Sinusitis
___Broken Teeth
___Dry Mouth
___Frequent Biting of the Cheek
___Burning Tongue Sensation

Symptom History

On what date, or approximate date, did your condition/symptoms first occur?___________________________

Can you relate your pain/condition to a motor vehicle accident or traumatic injury? ☐ yes ☐ no

If yes, please explain: ___________________________

Does any family member have a sleep breathing disorderor Obstructive Sleep Apnea? ☐ yes ☐ no

If yes, who: ___________________________

Does any family member have the same or a similar problem? ☐ yes ☐ no

If yes, please explain: ___________________________

Additional Information

Is there anything else you would like us to know?

____
____
____
____
____
____
____
____

Signature

I agree, the above information is accurate and complete to the best of my knowledge.

Patient Signature: ___________________________Date: ___________

Parent/Guardian Signature: ___________________________Date: ___________