FACIAL PAIN DYSFUNCTION EVALUATION

PERSONAL INFORMATION

Name _____ Birthdate ____/____/____ Age_____

Home # (____)_____ Cell # (____)_____ Work # (____)_____

Address_____ Apt. # ____ City _____ State____ Zip _____

E-Mail Address: _____

Patients Social Security #_____ Drivers License # _____

____ Married ____Single ____Divorced ____ Separated ____ Widowed Children (ages) _____

Occupation _____ Employer Name _____ Years Employed _____

Person to contact in case of Emergency _____ Relationship _____

Address _____ City_____ State ____ Zip _____ Phone # (____)_____

Person responsible for this account _____ Relationship _____

Address _____ City_____ State ____ Zip _____ Phone # (____)_____

Physician _____Phone # (____)_____

Address _____ Suite # _____ City _____ Zip _____

Dentist _____Phone # (____)_____

Address _____ Suite # _____ City _____ Zip _____

Who referred you to this office? _____Phone # (____)_____

Address _____ Suite # _____ City _____ Zip _____

INSURANCE INFORMATION

Name of Policy Holder _____ Birthdate ___/___/___ Social Security # _____

Address_____ Apt. # ____ City_____ State____ Zip _____ Phone # (____)_____

Policy Holder Employer Name_____ Phone # (____)_____

Medical Insurance Company_____ ID #_____ Group/Policy #_____

Address_____City_____State____ Zip_____ Phone # (____)_____

Dental Insurance Company_____ ID #_____ Group/Policy #_____

Address_____City_____State____ Zip_____ Phone # (____)_____

In your own words, describe your present problem.

When did your problem start? _____ What do you feel caused your problem to start?

Describe the difference in your symptoms now and when they first began.

Circle (Y) if any of the following relate to your present problem. Circle (R) for right and (L) for left where applicable. Indicate the most to least severe with #1, 2, 3, etc for each problem. #1 being the worst.

Y R L Headaches	Y R L Neckaches	Y R L Jaw Noises
Y R L Ringing of ears	Y R L Chest pain	Y R L Difficult to open/close mouth
Y R L Ear drainage	Y R L Tooth pain	Y R L Can't open/close mouth fully
Y R L Ear pain	Y R L Finger numbness	Y R L Can't get back teeth together
Y R L Fullness in ears	Y R L Visual Changes	Y R L Can't get front teeth together
Y R L Eye Pain	Y Jaw locking	Y R L Jaw joint pain
Y Frequent Stress	Y Hard to Swallow	Y R L Facial pain
Y Dizziness	Y Sore throat	Y R L Facial burning
Y Chronic fatigue	Y Upper back pain	Y R L Facial numbness
Y Nausea/vomiting	Y Lower back pain	Y R L Facial swelling
Y Poor sleep	Y Clenching teeth	Y Grinding teeth

Other (describe)

List all other treatment you have had for your problem: (need more space? : **download Complaint History**)

Date	Dr. Name	Treatment	Results

Why do you feel any past treatment was unsuccessful?

Explain what you expect treatment to do for you:

What does your problem keep you from doing?

List all doctors you are presently seeing not listed elsewhere on this form. Include phone number and for what reason.

Y N Are you in good health Date of last physical exam_____
Y N Are you under the care of a physician now? Why?_____
Y N Have you ever been hospitalized? Why?_____
Y N Have you ever had a serious illness? What?_____
Y N Have you ever seen a psychologist or a psychiatrist? Why?_____
Y N Do you wear a cardiac pacemaker? Y N Are you pregnant?
Y N Do you smoke or drink alcohol? How much per day? Tobacco_____ Alcohol_____
Y N Do you consider yourself a nervous person? Y N Are you easily upset?
Y N Do you exercise regularly? How? _____ Y N Does it change your pain?
Y N Do you have trouble getting to sleep or staying asleep? Y N Do you snore?
Y N Do you clench or grind your teeth? Night Day Do you sleep on your: Back Side Stomach
R L On which of your mouth do you chew? Why?_____

Check any of the following which you have had or now have:

____Anemia	____Blood disease	____Oral ulcers
____Heart disease	____Hepatitis	____Sinus problems
____High blood pressure	____Kidney disease	____Arthritis
____Respiratory disease	____Tumors	____Head injuries
____Tuberculosis	____Radiation treatment	____Stomach ulcers
____Nervous disorders	____Aids	____Venereal disease
____Diabetes	____Chemotherapy	____Epilepsy
____Rheumatic fever	____Asthma	____Mental disorders
____Thyroid disease	____Fainting Spells	____Seizures
____Marked weight change	____Night sweats	____Skin rashes
____Change in appetite	____Loss of hearing	____Stroke
____Depression	____Loss of energy	____Constipation
____ Eye Surgery	____Osteoporosis	____Hormonal problems

List all medication you are allergic to_____

List the name and dose of **All** medication you now take (example: Prozac 20mg., 2x/day, am/pm)
(If you have tried or used other meds and need more space: download Medication History)
Name of Medication Amount(mg) Number of doses per day

Is there any disease, accidents, traumatic events or contributing factors that you think could be associated with your chief complaint that I should know about? If so, Please discuss.

List any change in occupation, residence, relationships, life style, financial status, divorce, separation, death, emotional distress, changes or new medications which may have occurred just before or during the time of your problem.

If the first answer to each section is **NO (N)**, go to the next section.

Y N Does your jaw make noise? Popping☐ Clicking☐ Crackling☐ Grating☐ Other:
Which side? **R L** How often? Opening☐ Closing ☐ Eating ☐ Yawning ☐ Other:
When did you first notice these noises?_____ Can you make noises at will? **Y N**
Y N Is there pain when your jaw makes these noises?
Y N Has the noise changed since you first noticed it? How?

Y N Has your jaw ever stuck so you could **NOT OPEN** wide? Which side **R L** Both
When? Eating☐ Talking☐ Awakening☐ Other_____
How often? Daily☐ Weekly☐ Monthly☐ Other_____
When was the last time this happened?_____
What is the longest it has stayed locked? Seconds☐ Minutes☐ Hours☐ Days☐ Other:
Y N Can you unlock your jaw? How?_____
When your jaw unlocks can you immediately open wide? **Y N or:** does it take a while before you can open wide? How long? Minutes☐ Hours☐ Days☐ Weeks☐ Other:

Y N Has your jaw ever stuck so you could **Not Close or get your teeth together**? Which side? **R L** Both
When? Yawning☐ At the Dentist☐ Eating☐ Other_____
How often? Daily☐ Weekly☐ Monthly☐ Other_____
When was the last time this happened? _____
What is the longest it has stayed locked? Seconds☐ Minutes☐ Hours☐ Other:_____
Y N Can you unlock your jaw? How?_____

Y N If your jaw does not make any type of noise **now**, has it made noise in the past?
Which side? **R L** When did the noise stop? _____

Y N Do you suffer from headaches? Right Left Both
Y N Do you feel you have several types of headaches? Below mark: **M** for Mild ; **S** for Severe
Where do they occur? Temples☐ Eyes☐ Forehead☐ Back of head☐ Neck☐ Other:
How often do they occur? Daily☐ Weekly☐ Monthly☐ Yearly☐ Other:
How long do they last? Seconds☐ Minutes☐ Hours☐ Days☐ Weeks☐ Other:
When are they worst? 3-6 am☐ waking up☐ afternoon☐ evening☐ Other:
Y N Are you aware when your headache is going to start? How _____
Y N Have you seen a specialist for your headache? Who _____
Y N Do you take medication for your headache? What _____

Check any of the following which occur with your (**M)**ild and/or (**S)**evere headache:

Nausea☐ Vomiting☐ Visual changes☐ Confusion☐ Burning☐ Numbness☐ Sweating☐
Paralysis☐ Eye Tearing☐ Throbbing☐ Sensitivity to light☐ or noise☐ Other

Circle any of the following which may start your headache:

Stress☐ Tension☐ Exercise☐ Fatigue☐ Sleep☐ Body positions☐ Head positions☐
Time of Day☐ Time of month☐ Time of year☐ Jaw movements☐ During/after sex☐
Certain foods☐ Certain people☐ Your job☐ Other _____

The following pertains to your chief complaint

Circle **(+)** if any of the following starts or increases your pain : **(-)** if it stops or reduces your pain

+	-	opening your mouth	+	-	cold inside mouth	other:
+	-	closing your mouth	+	-	cold outside mouth	+ -
+	-	yawning	+	-	heat inside mouth	+ -
+	-	eating	+	-	heat outside mouth	+ -
+	-	talking	+	-	fatigue	
+	-	kissing	+	-	dampness	
+	-	moving jaw side to side	+	-	weather changes	
+	-	moving jaw forward	+	-	massage	
+	-	clenching teeth together	+	-	exercise	
+	-	turning head L or R	+	-	tension/stress	
+	-	looking up	+	-	sleep	
+	-	singing	+	-	lying down	
+	-	bending over	+	-	sitting up or standing after lying	

When was the last time you remember not having pain:
Is your pain : Hourly☐ Daily☐ Weekly☐ Monthly☐ Other
How long does your pain last: Seconds☐ Minutes☐ Hours☐ Days☐ Week☐ Continuous☐
When is your pain worse: Sleeping☐ Awakening☐ Mid-Day☐ Bed Time☐ Eating☐ During the Week☐
Weekends☐ Work☐ Around Certain People☐ Certain Situations☐

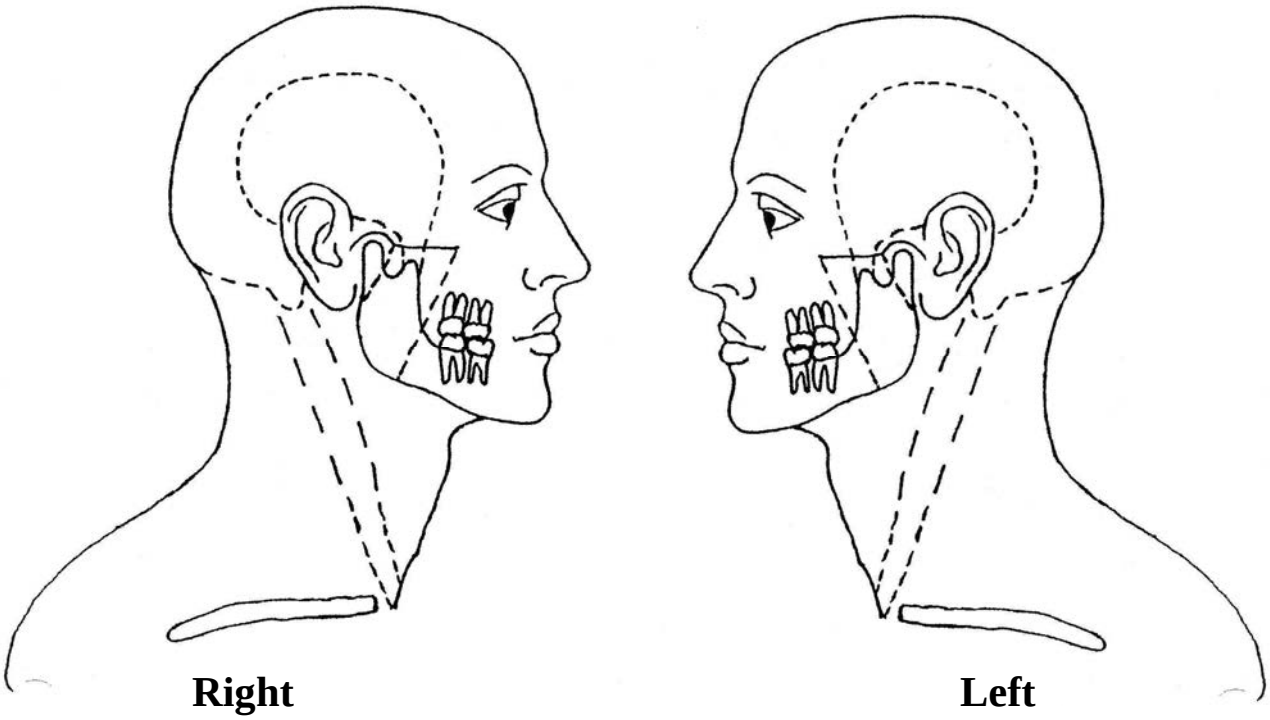
Some of the word groups below will describe your most significant pain. Circle the words in the word group that best describes your pain. Leave out any word-group that does not pertain to your pain. Use only a single word in each word group that best applies to you.

Flickering	Jumping	Pricking	Sharp
Quivering	Flashing	Boring	Cutting
Pulsing	Shooting	Drilling	Lacerating
Throbbing		Stabbing	
Beating		Lancinating	
Pounding			
Pinching	Tugging	Hot	Tingling
Pressing	Pulling	Burning	Itchy
Gnawing	Wrenching	Scalding	Smarting
Cramping		Searing	Stinging
Crushing			
Dull	Tender	Tiring	Sickening
Sore	Taut	Exhausting	Suffocating
Hurting	Rasping		
Aching	Splitting		
Heavy			
Fearful	Punishing	Wretched	Annoying
Frightful	Grueling	Blinding	Troublesome
Terrifying	Cruel		Miserable
	Vicious		Intense
	Killing		Unbearable
Spreading	Tight	Cool	Nagging
Radiating	Numb	Cold	Nauseating
Penetrating	Drawing	Freezing	Agonizing
Piercing	Squeezing		Dreadful
	Tearing		Torturing

Circle Your Level of Pain

Now	(none)	1	2	3	4	5	6	7	8	9	10	
Average		1	2	3	4	5	6	7	8	9	10	
Worst		1	2	3	4	5	6	7	8	9	10	Last time you had severe pain:
Eating		1	2	3	4	5	6	7	8	9	10	
Talking		1	2	3	4	5	6	7	8	9	10	
Smiling, Kissing, etc...		1	2	3	4	5	6	7	8	9	10	
Yawning		1	2	3	4	5	6	7	8	9	10	
Sleeping		1	2	3	4	5	6	7	8	9	10	

On the diagram below, circle the areas of your pain. If you have several types of pain, label each area circled with a description of the pain for that area. Examples: headache, throbbing pain, dull pain, stabbing pain, burning pain, etc... Mark the area of greatest pain with an **X** in the circle. Feel free to use colors, legends, anything to clarify different pains, times of pain, severity etc.



Right **Left**

Damon Spencer, DDS

3604 Preston Rd
Suite 500
Plano, TX 75093
Phone: (972) 758-2200

RELEASE OF RECORDS

I, _____, hereby authorized Dr. Spencer, who has examined and/or treated me (or my child), to release photo static copies, (as well as have conversations with previous or referring doctors including pharmacies, insurance companies), of any and all information related to my (or my child's) physical condition past, present, or future. This includes any and all history, physical exam, pathological and x-ray reports, pharmacy records, diagnosis, x-rays, prognosis and any other information including the charges and/or statements for medical care.

I, _____, hereby authorize any doctors who have examined and/or treated me (or my child) to release photo static copies of any and all information related to my physical condition past, present, or future. This includes any and all histories, physical exams, pathological and x-ray reports, pharmacy records, diagnosis, x-rays, prognosis, and any other information to:

Damon Spencer, D.D.S
3604 Preston Rd.
Suite 500
Plano, TX 75093

I expressly understand and agree that no liability of any nature should by attached to Dr. Spencer, or my (or my child's) other treating doctors, in acting on this authorization and request.

_____ _____
Patient Signature Date
(or Parent/Guardian if patient is under 18 years of age)

Damon Spencer, D.D.S.
3604 Preston Rd., Suite 500
Plano, TX 75093

Cancellation Policy
Please read carefully before signing.

Dr. Spencer has continued to strive to provide the highest standard of care to each patient by scheduling appointments on an individual basis. We do not double book our patients and try to allow adequate time to provide an in depth, thorough evaluation and treatment at each appointment. In order to continue to provide the highest quality of care to each and every patient and to offer treatment in a timely manner to as many patients in pain as possible it has become necessary to ask for a 48 "business" hour notice in case of cancellation.

While we do understand that there may be occasional emergencies that are unforeseen, we will be enforcing this policy with a "no show" charge equal to the office visit scheduled. This charge will be payable before or at your next appointment.

Thank you for your cooperation. Dr. Spencer and staff look forward to providing you with continued excellent care and treatment.

Patient Signature_____Date_____

Damon Spencer, DDS
3604 Preston Rd., Suite 500
Plano TX 75093

Medication Policy

Effective immediately, this office will require a 24 – 48 hour window to fill most medications.

Medications will not be refilled over weekends. Refills are not considered an emergency.

Requests made after 1 p.m. daily will not be authorized until the following 24 – 48 hour period.

For patients who are taking narcotic pain medication, you must be seen in the office for refills. No refills will be given by phone or fax.

I have read and understand the above policy.

Patient Signature Date

Chronological History of Chief Complaint

use as much space as you need and as much detail as possible (add pages if necessary)

Timeline is a very important tool that gives a "snapshot" of your chief complaint and other complaints that have developed since the onset of your problem. Besides the listed categories, think about the time of day your symptoms were worse in the timeline. Even if you can't remember all the details any information is helpful. One reason for this information is to make sure tests, medications, etc. that you have already taken are not repeated. Once you start treatment Dr. Riggs will keep the timeline going for you.

Year or Age						
Symptoms						
Dr.'s seen & specialty						
Tests, Studies, Labs, MRI, CT, etc. (findings)						
Treatment, Meds, Physical therapy, Chiropractic, Splits, Dental Work, Injections, Referred to another dr.						
Duration Of TX						
Results of Treatment						

Current Medications

Date Prescribed	Medication and Dose	How Do You Take It	Prescribing Dr.	Purpose	Response

Previous Medications Tried

Name of Medication	Why Was it Taken	How Long in Use	Why Discontinued