Patient Name _____ Date _____

List any symptoms since your last visit that you want to bring to my attention _____

_____

_____

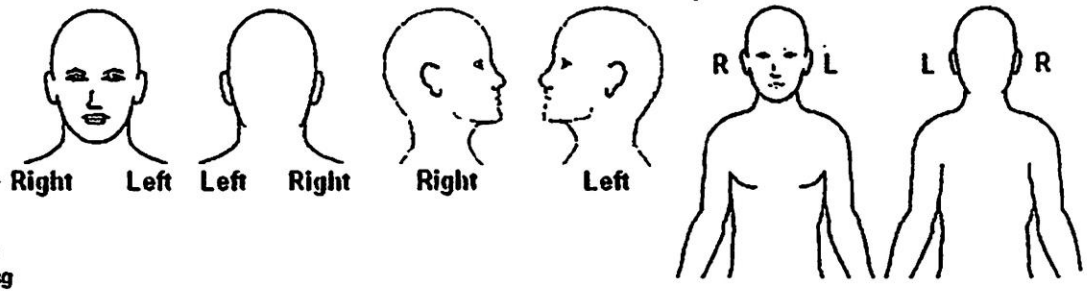
DRAW YOUR CURRENT PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN |||||||

MODERATE PAIN ʌʌʌʌ

SEVERE PAIN ////////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating



DEGREE OF DISCOMFORT

Indicate your current degree of discomfort or pain level by circling the corresponding numbers below:

Chief Complaints	No Pain	Mild Pain	Moderate Pain	Severe	Worst Possible
☐ Back Pain	0	1 2 3 4	5 6	7 8 9	10
☐ Dizziness	0	1 2 3 4	5 6	7 8 9	10
☐ Ear Pain	0	1 2 3 4	5 6	7 8 9	10
☐ Ear Congestion	0	1 2 3 4	5 6	7 8 9	10
☐ Eye Pain	0	1 2 3 4	5 6	7 8 9	10
☐ Facial Pain	0	1 2 3 4	5 6	7 8 9	10
☐ Fatigue	0	1 2 3 4	5 6	7 8 9	10
☐ Headaches	0	1 2 3 4	5 6	7 8 9	10
☐ Inability to open mouth	0	1 2 3 4	5 6	7 8 9	10
☐ Jaw Clicking	0	1 2 3 4	5 6	7 8 9	10
☐ Jaw Joint Noises	0	1 2 3 4	5 6	7 8 9	10
☐ Jaw Locking	0	1 2 3 4	5 6	7 8 9	10
☐ Jaw Pain	0	1 2 3 4	5 6	7 8 9	10
☐ Limited Mouth Opening	0	1 2 3 4	5 6	7 8 9	10
☐ Muscle Twitching	0	1 2 3 4	5 6	7 8 9	10
☐ Neck Pain	0	1 2 3 4	5 6	7 8 9	10
☐ *Pain when Chewing*	0	1 2 3 4	5 6	7 8 9	10
☐ Ringing in Ears	0	1 2 3 4	5 6	7 8 9	10
☐ Shoulder Pain	0	1 2 3 4	5 6	7 8 9	10
☐ Sinus Congestion	0	1 2 3 4	5 6	7 8 9	10
☐ Throat pain	0	1 2 3 4	5 6	7 8 9	10
☐ Tinnitus	0	1 2 3 4	5 6	7 8 9	10
☐ Visual Disturbances	0	1 2 3 4	5 6	7 8 9	10
☐ Muscle Soreness	0	1 2 3 4	5 6	7 8 9	10

Patient Signature _____ Date _____