ADVANCED DENTISTRY AND AESTHETICS

Craniofacial Pain Chief Complaint Index

Name:_____ Date:_____

Please Indicate your main complaints in order of their current importance

1._____
2._____
3._____

Key

Current: Y = Yes N = No

Frequency: 1 = Monthly 2 = Weekly 3 = Daily 4 = Constant

Side: R= Right L = Left

Intensity: 0 = No Pain, 10 = Most Severe Pain

	Current		Frequency	Side		Intensity
Ear Problems						
Buzzing/ Ringing Sounds (tinnitus)	Y	N	_____	R	L	_____
Diminished Hearing	Y	N	_____	R	L	_____
Ear Pain without Infection	Y	N	_____	R	L	_____
Clogged/Stuffy/ Itchy Ears	Y	N	_____	R	L	_____
Balance Problems (vertigo)	Y	N	_____			_____
Head Pain, Headaches, and Facial Pain						
Forehead	Y	N	_____	R	L	_____
Temples	Y	N	_____	R	L	_____
Top of Head	Y	N	_____	R	L	_____
Migraine Type Headaches	Y	N	_____	R	L	_____
Cluster Headaches	Y	N	_____	R	L	_____
Sinus Headaches	Y	N	_____	R	L	_____
Occipital (back of head) Headaches	Y	N	_____	R	L	_____
Hair/Scalp Painful to Touch	Y	N	_____	R	L	_____
Eye Pain and Problems						
Eye pain: Above, Behind, and Below	Y	N	_____	R	L	_____
Bloodshot Eyes	Y	N	_____	R	L	_____
Blurring of Vision	Y	N	_____	R	L	_____
Bulging of Appearance	Y	N	_____	R	L	_____
Pressure Behind Eyes	Y	N	_____	R	L	_____
Light Sensitivity	Y	N	_____	R	L	_____
Watery Eyes	Y	N	_____	R	L	_____
Drooping of the Eye Lids	Y	N	_____	R	L	_____
Sleep						
Waking up Multiple Times a Night	Y	N	_____			_____

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Tired/Drowsy During the Day	Y	N	_____			_____
Waking up with Headaches	Y	N	_____			_____

Neck and Shoulder Problems	**Current**		**Frequency**	**Side**		**Intensity**
Lack of Mobility/Reduced Range of Motion	Y	N	_____	R	L	_____
Stiffness	Y	N	_____	R	L	_____
Neck Pain	Y	N	_____	R	L	_____
Tired, Sore Neck	Y	N	_____	R	L	_____
Shoulders Aches	Y	N	_____	R	L	_____
Upper and Lower Back Pain	Y	N	_____	R	L	_____
Arm and Fingers Tingling, Numbness, or Pain	Y	N	_____	R	L	_____
Jaw and Jaw Joint Problems						
Pain in Jaw Joints	Y	N	_____	R	L	_____
Clicking, Popping Jaw Joints	Y	N	_____	R	L	_____
Grating Sounds	Y	N	_____	R	L	_____
Jaw Locking Open or Closed	Y	N	_____	R	L	_____
Pain in Cheek Muscles	Y	N	_____	R	L	_____
Uncontrollable Jaw/Tongue Movements	Y	N	_____	R	L	_____
Mouth, Face, Cheek, and Chin Problem						
Discomfort	Y	N	_____	R	L	_____
Inability to Open Smoothly/Evenly	Y	N	_____	R	L	_____
Jaw Deviates to One Side on Opening	Y	N	_____	R	L	_____
Inability to Find Bite	Y	N	_____			_____
Limited Opening	Y	N	_____			_____
Pain when Chewing	Y	N	_____			_____
Teeth and Gum Problems						
Clenching	Y	N	_____			_____
Grinding	Y	N	_____			_____
Looseness/ Soreness of Back Teeth	Y	N	_____			_____
Tooth Pain	Y	N	_____			_____
Throat Problems						
Swallowing Difficulties	Y	N	_____			_____
Tightness of Throat	Y	N	_____			_____
Sore Throat Without Infection	Y	N	_____			_____
Voice Fluctuations	Y	N	_____			_____
Laryngitis	Y	N	_____			_____

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Frequent Coughing or Constant Clearing of Throat	Y	N	_____	_____
Feeling of Foreign Objects in Throat	Y	N	_____	_____
Tongue Pain	Y	N	_____	_____
Salivation	Y	N	_____	_____
Pain in hard Palate (Roof of Mouth)	Y	N	_____	_____

Other Symptoms Not Listed Above Yes / No

If yes please describe: _____
_____
_____
_____
_____
_____

Are these symptoms related to an accident (Automobile, Personal injury, ect) Yes / No
If yes date of accident: _____

Fill out this section if you are already in treatment:

_____ I am satisfied with where my symptoms and my results are at and I am ready to move forward with the next phase of treatment in my treatment plan.

_____ I would like to see better results with the following:
_____
_____
_____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____