9199 Reisterstown Rd #203B
Owings Mills, MD 21117

Patient Questionnaire For Headaches & Facial Pain

Name: ______________________________ Occupation: _________________________ Date: _________________

Leisure Activities: ____

Circle each over-the-counter medications you take:

Antacids	Antihistamines	Aspirin
Decongestants	Ibuprofen/Advil/Motrin/Aleve	
Laxatives	Tylenol	Vitamin/mineral supplements

Other: ____

What medications have your doctors prescribed (include pills, injections, skin patches)?

____

Do you have any scars (injury or post-surgical) anywhere on your body? Yes No

If yes, where? ____

Circle each you are under care of:

Chiropractor	Dentist	Ear Nose and Throat (ENT)
Eye Doctor	Medical Doctor (MD)	Osteopath (DO)
Physical Therapist	Psychiatrist/Psychologist	

Other: ____

What situations cause stress to you? ____

When do you remember an initial onset of headaches/facial pain? ______________________________

What appear to precipitate the headaches/facial pain? _____________________________________

How often do you get headaches/facial pain? ____

How long does the headache/facial pain last? ____

What do you do to relieve the headache/facial pain? ____

Do you have any of the following?

Yes	No	Neck pain
Yes	No	Pain, numbness, or tingling in any of your limbs (arms, legs)
Yes	No	Recent weakness
Yes	No	Memory loss/confusion
Yes	No	Difficulty concentrating on a task
Yes	No	Difficulty sleeping at night

9199 Reisterstown Rd #203B
Owings Mills, MD 21117

Yes No Sensitivity to sound

Yes No Nausea or vomiting

Yes No Did you hit your head or gotten hit in the head with an object?

Yes No Are the symptoms worse during a particular time(s) of the day?

Yes No Do you get fatigued easily?

Yes No Does your headache worsen with reading?

Yes No Have you ever been told that you grind your teeth?

Yes No Have you been told to or currently wear a night guard?

Yes No Have you recently undergone dental work or kept your mouth open (15+ min. at a time)?

Yes No Do you wear dentures?

Yes No Do you have any pain, popping, or clicking in your jaw?

Yes No Do you have difficulty breathing through one or both sides of your nose?

Yes No Have you ever fallen hard on your tailbone/buttocks?

Yes No Are you or could you be pregnant?

Do you ever experience?

Yes	No	Facial pressure or pain	Yes	No	Need to clear your throat often
Yes	No	Sinus congestion	Yes	No	Ear pressure, crackling, clogging
Yes	No	Post-nasal drip	Yes	No	Chronic, watery eyes
Yes	No	Diminished sense of smell	Yes	No	Recent sinus infection

Yes No Do you consume alcohol?

Yes No Do you consume caffeinated foods/drinks?

Yes No Do you smoke?

Circle any diseases/disorders you have ever been diagnosed with:

Allergies	Arthritis	Asthma	Cancer	GI Disorders
Depression	Deviated septum	Diabetes	Heart disorder	Hypertension
Multiple Sclerosis	Seizures	Stroke	TMJ dysfunction	Tuberculosis
Vertigo/Dizziness	Visual problems	Other: _____		

Patient signature Date