Thank you for selecting the Head And Neck Diagnostic Center for evaluation of your problem. We look forward to meeting you. To help us best serve you and make your visits most time-efficient for you, we ask that prior to your first visit, you complete all the forms in this booklet to the best of your ability and as completely as possible.

*It is vital that you bring this completed booklet with you on your first visit.* You will notice that there is a page on which to describe the history of your problem. If you would prefer (we would) instead of filling it in by hand, you can provide separate typed pages.

Additionally, please bring any prior radiologist reports, x-rays, MRI, or CAT scans you may have, or can get, which were taken with respect to this problem. If you wear or have worn a TMJ appliance or night guard, and you still have it or them, please bring it or them.

Once again, we look forward to meeting you and helping you with your problem. If you have any questions please feel free to call the Center.
**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>TITLE: Mr.  Mrs.  Ms.  Dr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>STREET ADDRESS: _______________________ SUITE//apt# ___________</td>
</tr>
<tr>
<td>CITY: ___________________________ STATE: _______ ZIP: _______</td>
</tr>
<tr>
<td>HOME PHONE: _____ / _____ - _____ SOCIAL SECURITY NUMBER _____-<strong><strong>-</strong></strong></td>
</tr>
<tr>
<td>DATE OF BIRTH: <strong><strong>/</strong></strong>/____ AGE: _____ SEX: _____ MARITAL STATUS: _______</td>
</tr>
<tr>
<td>EMPLOYED BY:_____________________________ PHONE: _____ / _____ - _____</td>
</tr>
<tr>
<td>ADDRESS:______________________________CITY: ____________ STATE: ____ ZIP: _____</td>
</tr>
<tr>
<td>IF UNDER 18:</td>
</tr>
<tr>
<td>PARENT/GUARANTOR: _________________________ RELATION: __________</td>
</tr>
<tr>
<td>ADDRESS: _________________________ PHONE: _____ / _____ - _____</td>
</tr>
</tbody>
</table>

**MEDICAL INSURANCE**

| COMPANY: _________________________ PHONE: ____ / ____ - ____ |
| ADDRESS:______________________________CITY: ____________STATE: ____ZIP: _____ |
| INSURED'S NAME: __________________ INSURED'S DATE OF BIRTH__________ |
| RELATION TO INSURED: __SELF __SPOUSE __CHILD __OTHER ________________ |
| INSURED'S EMPLOYER ____________________________________________ |
| EMP'S ADDRESS: ________________ CITY: __________ STATE: ____ ZIP: ___ |
| PLAN/GROUP # __________________ INSURED'S I.D. # __________________ |

**WHO REFERRED YOU TO THE HEAD AND NECK DIAGNOSTIC CENTER?**

NAME:
INSURANCE INFORMATION

Benefits for treatment for Temporomandibular Joint Dysfunction (TMJ) are customarily filed under a major medical insurance policy, not a dental plan.

Most major medical insurance may provide coverage for a portion of your TMJ therapy. A major medical insurance policy is actually a legal contractual agreement made between you or your employer and an insurance carrier. It establishes the responsibility of the insurance carrier to provide benefit payments to you or your dependents for any treatment that is considered to be an insured liability under the terms of that contract. If your policy provides coverage for “articular” or “joint disorders”, and does not specifically exclude Temporomandibular Joint Dysfunctions and Diseases, your policy should provide a reimbursement (usually 80% of reasonable and customary charges) of the fees paid by you for TMJ therapy.

We suggest that you review your medical insurance policy or “Benefits Booklet” so that you may be made aware of the specific limitations of your major medical contract. If your present policy does not contain the coverage that you think it contains, we suggest you change policies or purchase a rider for your present policy to get the coverage you desire.

This office does not deal directly with insurance carriers regarding benefits. We do not accept assignment of benefits nor can we commence treatment contingent upon payment by an insurance carrier. We deal directly with each patient individually and expect you to pay us for services as they are rendered on a visit by visit basis. This means that at the end of your appointment you must physically write out a check or sign a charge card slip.

This office will assist you by providing you with completed medical insurance forms listing the service/s actually performed. These forms will be generated by our computer system. We will also aid you by providing explanations of procedures to your insurance carrier if requested. We will not originate any telephone calls to your insurance carrier from this office. However, we will answer telephone requests from your insurance carrier on a reasonable basis. It is your responsibility to pursue reimbursement from your insurance carrier for monies you have paid to us for your treatment.

There are over 2300 insurance carriers, each having from one to several major medical policies in existence, and each one containing clauses that make it different from all the others. We advise you to read your policy carefully and to call your insurance carrier if you have any questions concerning your coverage for services rendered.

Thank you for your cooperation.

Signature _____________________________, Date _____________
**RELEASE OF DOCUMENTS**

I hereby authorize release of any medical information to any insurance carrier or attorney concerning my treatment and physical condition in order to process any claim for reimbursement of charges incurred at this office by me.

I hereby authorize release of any medical/dental information to any of my health care practitioners of record.

I hereby authorize the release of and receipt of any medical information from any of my doctors of record to A. Richard Goldman, D.D.S.

Name__________________________________     DATE _________________
Dr. Goldman and/or the Head and Neck Diagnostic Center performs no diagnostic, preventative dentistry nor dental treatment except that Necessary for Craniomandibular Disorders.

Although Dr. A. Richard Goldman and the Head and Neck Diagnostic Center is licensed as a general dentist in the state of Illinois, I specifically am seeking him or it out for problems related to craniomandibular disorders only, and I do not and will not, in any way, consider him, it, or any dentist employed by him or it as my personal dentist. I will not hold Dr. Goldman or the Head and Neck Diagnostic Center or any dentist employed by him or it responsible for the diagnosis and/or treatment of any dental diseases or processes other than those related to craniomandibular disorders. These other diseases or processes include, but are not limited to, tooth decay, missing teeth, abscesses, periodontal diseases, tumors, endodontic or periapical diseases, tooth position or skeletal anomalies, and emergency treatment not related to craniomandibular disorders.

I further declare that I am currently under the care of, and will remain under the care of a licensed dentist other than Dr. Goldman or the Head and Neck Diagnostic Center or any dentist employed by him or it for all of my dental needs other than craniomandibular disorders.

If I undergo treatment for craniomandibular disorders with Dr. Goldman, the Head and Neck Diagnostic Center or any dentist employed by him or it, I agree to have dental prophylaxis and dental examinations done by my dentist at least three times per year or more frequently if deemed necessary by my dentist. I agree to be solely responsible for keeping track of, and scheduling the appointments referred to in this paragraph.

Name ___________________________________________ Date ______________________
DEAR PATIENT: Please list below ALL health care practitioners (including ENT, neurologist, orthopedist, psychiatrist, etc.), dentists, chiropractors, osteopaths, physical therapists, or other health care providers that you have consulted.

PLEASE PLACE AN “X” TO THE LEFT OF YOUR REFERRING HEALTH CARE PRACTITIONER.

**PATIENT’S NAME:**

<table>
<thead>
<tr>
<th><strong>PERSONAL DENTIST:</strong></th>
<th>Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Diagnosis &amp; Treatment:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PERSONAL PHYSICIAN:</strong></th>
<th>Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Diagnosis &amp; Treatment:</td>
<td></td>
</tr>
</tbody>
</table>

**OTHER HEALTH CARE PRACTITIONERS**

<table>
<thead>
<tr>
<th><strong>NAME:</strong></th>
<th>Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Diagnosis &amp; Treatment:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>NAME:</strong></th>
<th>Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Diagnosis &amp; Treatment:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>NAME:</strong></th>
<th>Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Diagnosis &amp; Treatment:</td>
<td></td>
</tr>
</tbody>
</table>

**PATIENT’S NAME:** ____________________________
OTHER HEALTH CARE PRACTITIONERS (continued)

<table>
<thead>
<tr>
<th>NAME:</th>
<th>Specialty:</th>
<th>Address:</th>
<th>City/State/Zip:</th>
<th>Phone:</th>
<th>Diagnosis &amp; Treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAME:</td>
<td>Specialty:</td>
<td>Address:</td>
<td>City/State/Zip:</td>
<td>Phone:</td>
<td>Diagnosis &amp; Treatment:</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>----------</td>
<td>----------------</td>
<td>--------</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAME:</td>
<td>Specialty:</td>
<td>Address:</td>
<td>City/State/Zip:</td>
<td>Phone:</td>
<td>Diagnosis &amp; Treatment:</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>----------</td>
<td>----------------</td>
<td>--------</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAME:</td>
<td>Specialty:</td>
<td>Address:</td>
<td>City/State/Zip:</td>
<td>Phone:</td>
<td>Diagnosis &amp; Treatment:</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>----------</td>
<td>----------------</td>
<td>--------</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PLEASE REQUEST ADDITIONAL FORMS IF NEEDED (312.920.0505)
PLEASE HELP US UNDERSTAND YOUR PROBLEM AS COMPLETELY AS POSSIBLE

ON THIS OR SEPARATE SHEETS, STARTING FROM THE ONSET OF YOUR FIRST SYMPTOM PLEASE DESCRIBE, IN CHRONOLOGICAL ORDER, THE FOLLOWING: (GIVE DATES, IF POSSIBLE - MONTHS OR YEARS IF NECESSARY)

1. Initial symptoms
2. What precipitated these symptoms
3. Progression of symptoms
4. Healthcare professionals with whom you have consulted (names only)
5. Treatment given by these healthcare professionals and the results of these treatments
6. What makes your symptoms worse or better at this time
7. Any trauma that you have experienced to your head and neck - ever (to the best of your Knowledge)
8. Any automobile accidents in which you have been involved
9. Other information which you feel will help our understanding of your problem
WHY ARE YOU SEEKING TREATMENT?

PLEASE ORDER YOUR COMPLAINTS **BY NUMBER WITH #1 BEING MOST IMPORTANT**.

<table>
<thead>
<tr>
<th>Back Pain</th>
<th>Jaw Clicking</th>
<th>Pain While Chewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness</td>
<td>Jaw Joint Noises</td>
<td>Ringing In Ears</td>
</tr>
<tr>
<td>Ear Pain</td>
<td>Jaw Locking</td>
<td>Shoulder Pain</td>
</tr>
<tr>
<td>Ear/Sinus Congestion</td>
<td>Jaw Pain</td>
<td>Throat Pain</td>
</tr>
<tr>
<td>Facial Pain</td>
<td>Limited Mouth Opening</td>
<td>Tinnitus</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Muscle Twitching</td>
<td>Visual Disturbance</td>
</tr>
<tr>
<td>Headaches</td>
<td>Neck Pain</td>
<td></td>
</tr>
<tr>
<td>Can't Open Mouth</td>
<td>Pain Behind Eyes</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

CHECK ANY MEDICATIONS / SUBSTANCES TO WHICH YOU ARE ALLERGIC:

- [ ] Antibiotics
- [ ] Metals
- [ ] Aspirin
- [ ] Penicillin
- [ ] Barbiturates
- [ ] Plastics
- [ ] Codeine
- [ ] Sedatives
- [ ] Iodine
- [ ] Sleeping Pills
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthesia
- [ ] Other Allergens: ____________________________

Signature: ____________________________ Date: ____________________________
### CHECK ANY MEDICATIONS YOU ARE CURRENTLY TAKING --GIVE NAME AND DOSAGE:

| [ ] ANTIBIOTICS                        | [ ] INSULIN                         |
| [ ] ANTICOAGULANTS                    | [ ] MUSCLE RELAXER                  |
| [ ] BARBITUATES                       | [ ] ANTI ANXIETY                    |
| [ ] BLOOD THINNERS                    | [ ] PAIN MEDICATION                 |
| [ ] CODEINE                           | [ ] SLEEPING PILLS                  |
| [ ] CORTISONE                         | [ ] SULFA DRUGS                     |
| [ ] DIET PILLS                        | [ ] TRANQUILIZERS                   |
| [ ] HEART MEDS                        |                                         |

### OTHER MEDICATIONS:

| [ ] 1.                                      | [ ] 3.                                 |
| [ ] 2.                                      | [ ] 4.                                 |

### HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING CHECK WHERE APPROPRIATE

| [ ] ADENOIDS /TONSILS REMOVED          | [ ] DEPRESSION                        | [ ] GOUT                                |
| [ ] ANEMIA                             | [ ] DIABETES                          | [ ] HAY FEVER                           |
| [ ] ARTERIOSCLEROSIS                  | [ ] DIFFICULTY CONCENTRATING          | [ ] HEARING IMPAIRMENT                   |
| [ ] ASTHMA                             | [ ] DIZZINESS                         | [ ] HEART MURMUR                        |
| [ ] AUTOIMMUNE DISORDERS               | [ ] EMPHYSEMA                         | [ ] HEART DISORDER                      |
| [ ] BLEEDING EASILY                    | [ ] EPILEPSY                          | [ ] HEART PACEMAKER                     |
| [ ] BLOOD PRESSURE HIGH LOW            | [ ] EXCESSIVE THIRST                  | [ ] HEART PALPITATIONS                  |
| [ ] BRUIISING EASILY                   | [ ] FLUID RETENTION                   | [ ] VALVE REPLACEMENT                   |
| [ ] CANCER                             | [ ] FREQUENT COUGH                    | [ ] HEMOPHILIA                          |
| [ ] CHEMOTHEROPY                       | [ ] FREQUENT ILLNESS                  | [ ] HEPATITIS                           |
| [ ] CHRONIC FATIGUE                    | [ ] FREQUENT STRESS                   | [ ] HYPOGLYCEMIA                        |
| [ ] COLD HANDS & FEET                  | [ ] GENERAL ANESTHESIA                |                                         |
| [ ] CURRENT PREGNANCY                  | [ ] GLAUCOMA                          |                                         |
MEDICAL HISTORY
CONTINUED-PLEASE CHECK

[ ] MUSCULAR DYSTROPHY
[ ] NEED EXTRA PILLOWS (TO HELP BREATHING AT NIGHT)
[ ] SHORTNESS OF BREATH
[ ] SINUS PROBLEMS

[ ] IMMUNE SYSTEM DISORDER
[ ] NEED EXTRA PILLOWS (TO HELP BREATHING AT NIGHT)
[ ] SKIN DISORDER

[ ] INJURY TO:
___FACE ___MOUTH
___NECK ___TEETH
[ ] NERVOUS SYSTEM IRRITABILITY
[ ] NERVOUSNESS
[ ] NEURALGIA
[ ] SLOW HEALING SORES
[ ] SPEECH DIFFICULTIES
[ ] STD

[ ] INJURY TO:
[ ] OSTEOARTHRITIS
[ ] STROKE

[ ] INTESTINAL DISORDER
[ ] OSTEOARTHRITIS
[ ] SWOLLEN-STIFF-PAINTFUL JOINTS

[ ] JAW JOINT SURGERY
[ ] OVARIAN CYSTS
[ ] FREQUENT COLDs

[ ] KIDNEY PROBLEMS
[ ] PARKINSON'S DISEASE
[ ] EAR INFECTIONS / SORE THROATS

[ ] LIVER DISEASE
[ ] POOR CIRCULATION
[ ] TIRED MUSCLES

[ ] MENIERE'S DISEASE
[ ] PRIOR ORTHODONTICS
[ ] TUBERCULOSIS

[ ] MENSTRAL CRAMPS
[ ] PSYCHIATRIC CARE
[ ] TUMORS

[ ] MULTIPLE SCLEROSIS
[ ] RADIATION TREATMENT
[ ] URINARY DISORDERS

[ ] MUSCLE ACHES
[ ] RHEUMATIC FEVER
[ ] WISDOM TEETH REMOVAL

[ ] MUSCLE SHAKING (TREMORS)
[ ] RHEUMATOID ARTHRITIS

[ ] MUSCLE SPASMS OR CRAMPS
[ ] SCARLET FEVER

[ ] OTHER MEDICAL/DENTAL HISTORY INCLUDE ALL SURGERIES, WITH APPROXIMATE DATES AND TYPE OF ANESTHESIA USED

_________________________________________________________
_________________________________________________________
_________________________________________________________
_________________________________________________________
_________________________________________________________

SIGNATURE ___________________________ DATE ________________
**SYMPTOM KEY**

LOCATION: “L”=LEFT  “R”=RIGHT  “B”=BOTH SIDES

SEVERITY: “MI”=MILD  “MO”=MODERATE  “S”=SEVERE

FREQUENCY: “O”=OCCASIONAL  “F”=FREQUENT  “C”=CONSTANT

DURATION: “S”=SECONDS  “M”=MINUTES  “H”=HOURS  “D”=DAYS  “W”=WEEKS

**HEAD PAIN** USING KEY FOR REFERENCE, PLEASE CIRCLE AS APPROPRIATE

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>SEVERITY</th>
<th>FREQUENCY</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>L R B FRONT OF YOUR HEAD</td>
<td>MI MO S</td>
<td>O F C</td>
<td>S M H D W</td>
</tr>
<tr>
<td>L R B ENTIRE HEAD</td>
<td>MI MO S</td>
<td>O F C</td>
<td>S M H D W</td>
</tr>
<tr>
<td>L R B TOP OF YOUR HEAD</td>
<td>MI MO S</td>
<td>O F C</td>
<td>S M H D W</td>
</tr>
<tr>
<td>L R B BACK OF YOUR HEAD</td>
<td>MI MO S</td>
<td>O F C</td>
<td>S M H D W</td>
</tr>
<tr>
<td>L R B IN YOUR TEMPLES</td>
<td>MI MO S</td>
<td>O F C</td>
<td>S M H D W</td>
</tr>
<tr>
<td>L R B ________________</td>
<td>MI MO S</td>
<td>O F C</td>
<td>S M H D W</td>
</tr>
<tr>
<td>L R B ________________</td>
<td>MI MO S</td>
<td>O F C</td>
<td>S M H D W</td>
</tr>
<tr>
<td>L R B ________________</td>
<td>MI MO S</td>
<td>O F C</td>
<td>S M H D W</td>
</tr>
</tbody>
</table>

**JAW PAIN**

PLEASE CIRCLE shaded areas for Center use only

- L R B JAW PAIN ON OPENING
- L R B JAW PAIN WHILE CHEWING
- L R B JAW PAIN AT REST

**EYE RELATED CONDITIONS**

PLEASE CHECK

- [ ] BLURRED VISION
- [ ] DOUBLE VISION
- [ ] EYE PAIN
- [ ] PAIN OR PRESSURE BEHIND EYES
- [ ] LIGHT SENSITIVITY
### Jaw Symptoms

**PLEASE CHECK**

- [ ] Jaw Clicks
- [ ] Jaw Locks Closed
- [ ] Jaw Locks Open
- [ ] Jaw Popping
- [ ] Teeth Clenching
- [ ] Teeth Grinding

### Ear Related Conditions

**PLEASE CHECK**

- [ ] Buzzing in the Ears
- [ ] Ear Congestion
- [ ] Ear Pain
- [ ] Hearing Loss
- [ ] Pain Behind the Ear

### Ear Conditions Cont.

**PLEASE CHECK**

- [ ] PAIN IN FRONT OF THE EAR
- [ ] Recurrent Ear Infections
- [ ] Tinnitus (Ear Ringing)

### Throat Neck and Back

**PLEASE CHECK**

- [ ] Tightness in Throat
- [ ] Lower Back Pain
- [ ] Middle Back Pain
- [ ] Back Pain-Upper
- [ ] Chronic Sore Throat
- [ ] Feel Foreign Object in Throat
- [ ] Difficulty in Swallowing
- [ ] Limited Movement in Neck
- [ ] Neck Pain
- [ ] Numb Hands or Fingers
- [ ] Sciatica
- [ ] Scoliosis
- [ ] Shoulder Pain
- [ ] Shoulder Stiffness
- [ ] Other

### Lifestyle Related Conditions

**PLEASE CHECK**

- [ ] Under Unusual Stress
- [ ] Recent Change in Lifestyle
- [ ] Recent Change in Work

### Throat Neck & Back Cont.

**PLEASE CHECK**

- [ ] Swelling in the Neck
- [ ] Swollen Glands
- [ ] Thyroid Enlargement

### Mouth & Nose

**PLEASE CHECK**

- [ ] Broken Teeth
- [ ] Burning Tongue
- [ ] Chronic Sinusitis
- [ ] Dry Mouth
- [ ] Frequent Biting of the Cheek
- [ ] Frequent Snoring
[ ] DRINK 4 OR MORE CUPS OF COFFEE DAILY?

[ ] SMOKE OR USE TOBACCO?

[ ] TAKE MORE THAN ONE ALCOHOLIC DRINK DAILY? [ ] IF YES, HOW MUCH _________________________

[ ] DOES ANY FAMILY MEMBER HAVE THE SAME OR SIMILAR PROBLEM?

    IF YES, PLEASE EXPLAIN _____________________________________________________________

WHAT MAKES YOUR PAIN/DISCOMFORT WORSE? _________________________________________

WHAT MAKES YOUR PAIN/DISCOMFORT BETTER? _________________________________________

[ ] HAVE YOU BEEN IN THE HOSPITAL FOR ANY REASON IN THE LAST 5 YEARS? IF YES PLEASE EXPLAIN

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

ADDITIONAL HEALTH HISTORY COMMENTS:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

SIGNATURE ___________________________ DATE ___________________________
DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN

MODERATE PAIN

SEVERE PAIN

B Burning
C Dull
H Heavy Pressure
N Numbing
S Sharp
T Tingling
R Radiating

EXAMPLE:

INDICATES:

N Miss, numb, par
D Moderate, dull pain
R Severe, radiating pain
H Heavy pressure

LEFT

RIGHT

LEFT

RIGHT

LEFT
IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT, THAT YOU FEEL IS RESPONSIBLE FOR YOUR PROBLEM, COMPLETE THIS SECTION. IF NOT, YOU ARE FINISHED

HISTORY OF ACCIDENT OR INCIDENT

DATE OF ACCIDENT OR INCIDENT: ____________________________________________

WERE YOU? PLEASE CHECK WHERE APPROPRIATE

[ ] A PASSENGER IN A VEHICLE    [ ] DID YOU FALL?
[ ] THE DRIVER OF A VEHICLE     [ ] WERE YOU HIT BY AN OBJECT
[ ] A PEDESTRIAN               [ ] DID YOU HIT AN OBJECT?
[ ] AT WORK                    [ ] OTHER:________________________________________

IF IN A VEHICLE, WHERE WAS THE VEHICLE HIT? If not, skip to next page

PLEASE CHECK

[ ] AT FRONT END     [ ] Head ON
[ ] AT REAR END     [ ] ON DRIVER'S SIDE
[ ] AT FRONT RIGHT AREA  [ ] ON PASSENGER'S SIDE
[ ] AT FRONT LEFT AREA    [ ] OTHER_______________________________________
[ ] AT REAR RIGHT AREA
[ ] AT LEFT REAR AREA
## INDICATE IF THERE WAS ANY DIRECT TRAUMA

**AUTO OR NON-AUTO**

**DID YOUR**

Please check:

- [ ] FOREHEAD
- [ ] FACE &middot; **<<FORCIBLY STRIKE>>**
- [ ] CHIN
- [ ] SIDE OF HEAD
- [ ] BACK OF HEAD
- [ ] TOP OF HEAD
- [ ] TEETH
- [ ] JAW
- [ ] OTHER: _______________________

- [ ] STEERING WHEEL
- [ ] WINDSHIELD
- [ ] PASSENGER'S SIDE WINDOW
- [ ] DRIVER'S SIDE WINDOW
- [ ] PASSENGER'S SIDE DOOR
- [ ] DRIVER'S SIDE DOOR
- [ ] HEAD REST
- [ ] SEAT
- [ ] ROOF
- [ ] INTERIOR OF CAR
- [ ] OTHER: _______________________

- [ ] ROOF
- [ ] INTERIOR OF CAR
- [ ] OTHER: _______________________

## WERE ANY AREAS OF YOUR BODY PAINFUL SHORTLY AFTER THE ACCIDENT?

Please check all appropriate:

- [ ] HEAD
- [ ] LEFT ARM
- [ ] NECK
- [ ] RIGHT ARM
- [ ] FACE
- [ ] LOWER BACK
- [ ] JAW
- [ ] UPPER BACK
- [ ] LEFT SHOULDER
- [ ] OTHER: _______________________
- [ ] RIGHT SHOULDER

When did symptoms start: __________

**BRIEFLY DESCRIBE THE HISTORY OF THE SYMPTOMS, ACCIDENT OR INCIDENT:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
<table>
<thead>
<tr>
<th>CHECK IF YES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] DID YOU GO TO THE HOSPITAL? IF YES [ ] BY CAR? [ ] BY AMBULANCE?</td>
</tr>
<tr>
<td>[ ] WERE YOU TAKEN TO THE HOSPITAL FOR X-RAYS &amp; EVALUATION __________________________________________________________________________</td>
</tr>
<tr>
<td>__________________________DATE YOU WERE RELEASED FROM THE HOSPITAL</td>
</tr>
<tr>
<td>WHICH HOSPITAL? ___________________________________________________________________________________________________________________________________________</td>
</tr>
<tr>
<td>WHAT TREATMENT, IF ANY, DID YOU RECEIVE AT THE HOSPITAL ___________________________________________________________________________________________________________________________________________</td>
</tr>
<tr>
<td>[ ] HAS A PHYSICIAN OR DENTIST EVER DIAGNOSED A TMJ DISORDER PRIOR TO THE ACCIDENT?</td>
</tr>
<tr>
<td>IF YES, PLEASE EXPLAIN ______________________________________________________________________________________________________________________________________________________________</td>
</tr>
<tr>
<td>IF YOU HAVE HAD A PREVIOUS ACCIDENT, PLEASE GIVE A DESCRIPTION: __________________________________________________________________________________________________________________________________</td>
</tr>
<tr>
<td>__________________________DATE: ________</td>
</tr>
<tr>
<td>NAMES AND ADDRESSES OF HOSPITALS AND DOCTORS WHERE YOU WERE TREATED FOR THIS PREVIOUS ACCIDENT __________________________________________________________________=================================================================</td>
</tr>
<tr>
<td>IF YOU HAVE MISSED ANY WORK BECAUSE OF THIS ACCIDENT PLEASE GIVE DATES: ____________________________________________________________________________________________________________________________________________</td>
</tr>
<tr>
<td>________</td>
</tr>
</tbody>
</table>

| SIGNATURE __________________________ DATE __________________________ |