


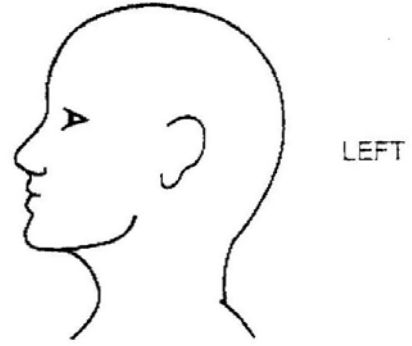
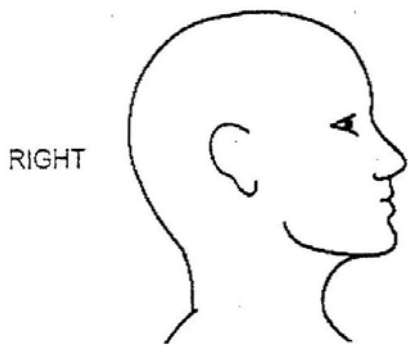
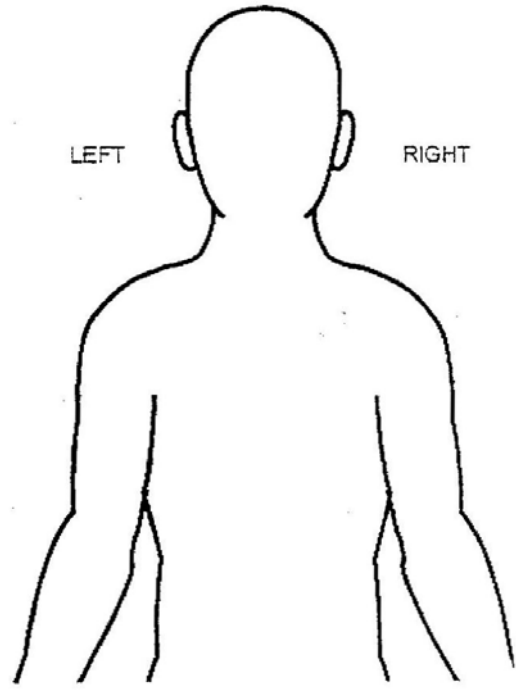
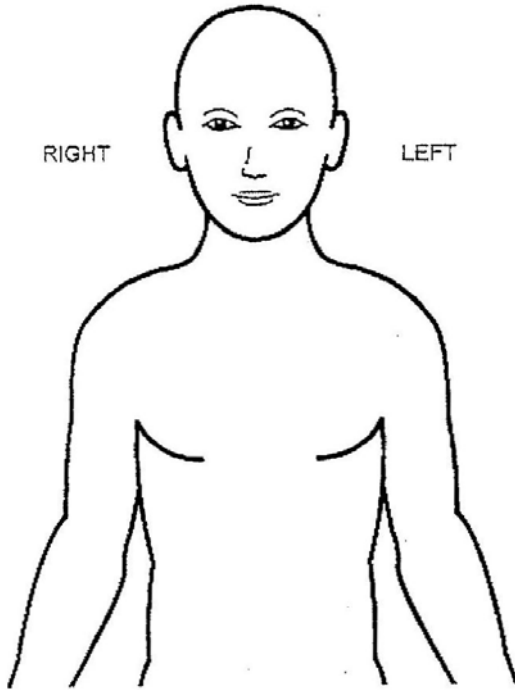
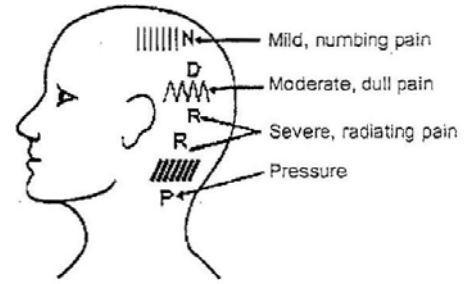


DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

- | | | |
|---------------|-----------------------------------------------------------------------------------|-------------|
| MILD PAIN |  | B Burning |
| | | D Dull |
| | | N Numbing |
| MODERATE PAIN |  | P Pressure |
| | | S Sharp |
| | | T Tingling |
| SEVERE PAIN |  | R Radiating |

EXAMPLE



Patient Signature _____ Date _____

HISTORY OF SYMPTOMS

When did your condition first occur?

What do you believe is the cause of your pain or condition? (Check the box that applies)

Motor vehicle accident

Work-related incident

Sporting injury/Playground injury

Illness

Fight

Fall

OTHER:

Have you missed any WORK as a result of the injury?

(please include length of time absent, and describe the task of employment that has become affected)

Have you been unable to carry out DAILY ACTIVITIES OF NORMAL LIFE as a result of the injury? (please describe the tasks of daily living that have become affected)

Has a doctor or dentist ever diagnosed a TMJ disorder prior to the accident/injury?

(please explain)

Have you ever been involved in a PREVIOUS accident/injury? Please explain.

Medical attention previously sought.

PRACTIONER	TREATMENT & APPROXIMATE DATE
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Medical doctor	
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Neurologist	
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Dentist	
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Physiotherapist	
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Chiropractor	
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Massage Therapist	
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OTHER:	
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HISTORY OF ACCIDENT (complete this section ONLY if you were involved in an accident or traumatic incident)

Date of Accident: (month/day/year)

Were you... (check all that apply)

A passenger in a vehicle?

The driver of a vehicle?

A pedestrian?

At work?

Did you fall?

Were you hit by an object?

OTHER:

If in a vehicle, where was the vehicle hit? (check all that apply)

Front end

Rear end

Front right area

Front left area

Head-on

Rear right area

Rear left area

Driver's side

Passenger's side

OTHER:

Indicate which body parts were painful shortly after the accident/incident?
(check all that apply)

Head

Neck

Face

Jaw

Left shoulder

Right shoulder

Left arm

Right arm

Lower back

Upper back

Indicate if there was any DIRECT trauma to... (check all that apply)

Forehead

Face

Chin

Side of head

Back of head

Top of head

Teeth

Jaw

OTHER:

Indicate the part of the vehicle that your body part (as checked above) struck forcibly...

Steering wheel

Windshield

Driver's side window

Passenger's side window

Driver's side door

Passenger's side door

Headrest

Seat

Roof

Interior of car

OTHER: