SYMPTOM EVALUATION QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____

Do you have any of the following symptoms:

Facial pain (G50.1)	☐ Yes ☐ No
Jaw pain or discomfort (R68.84)	☐ Yes ☐ No
Neck pain (M54.2)	☐ Yes ☐ No
Headaches (R51)	☐ Yes ☐ No
Migraine headache (G43.109)	☐ Yes ☐ No
Missing teeth (M89.58)	☐ Yes ☐ No
Nasal congestion or sinus problems (J32.0)	☐ Yes ☐ No
Muscle pain (M79.1)	☐ Yes ☐ No
Muscle inflammation (M60.80)	☐ Yes ☐ No
Ringing in the ears – Tinnitus (H93.19)	☐ Yes ☐ No
Ear pain – Otalgia (H92.09)	☐ Yes ☐ No
Facial swelling (R22.0)	☐ Yes ☐ No
Sleep related (G47.33)	☐ Yes ☐ No

Other symptom(s): _____

_____

_____

_____

X _____ _____

Signature of Patient or Legal Guardian Date