SYMPTOMS SCREENING FORM

Name _____ Age _____ Sex _____

Please circle any of the following symptoms you may have or have had:

HEAD/FACE
1. Forehead pain
2. Temple pain
3. Tension headaches
4. Migraine headaches
5. Sinus headaches
6. Back of head headache
7. Hair scalp tender to touch

EAR
1. Ear pain without infection
2. Decreased hearing
3. Clogged, itchy or stuffy
4. Ringing, buzzing
5. Dizziness
6. Balance problems

THROAT
1. Swallowing difficulties
2. Feeling of foreign object in throat
3. Sore throat without infection
4. Voice changes
5. Laryngitis
6. Frequent coughing or clearing

JAW
1. Jaw pain
2. Jaw joint pain
3. Clicking/popping jaw joint
4. Grating sound in jaw joint
5. Pain in cheek muscles
6. Jaw locks open/shut
7. Uncontrollable jaw movements
8. Deviates to one side on opening or closing

NASAL
1. Sinus pain
2. Sinus problems
3. Post nasal drip
4. Allergies

EYES
1. Pain in/around eyes
2. Bloodshot eyes
3. Sensitive to light
4. Tearing of eyes
5. Blurred vision
6. Pressure behind eye

NECK
1. Lack of mobility
2. Stiffness
3. Neck pain
4. Tired/sore neck muscles
5. Shoulder pain
6. Back pain: middle, lower
7. Arm/finger pain/numbness

MOUTH
1. Abnormal opening
2. Limited opening
3. Bad bite
4. Missing teeth
5. Excessive mouth breathing
6. Clench or grind teeth
7. Mouth discomfort
8. Inability to find “bite”

I have reviewed this form and answered to the best of my ability:

Signed:_____ Date:_____