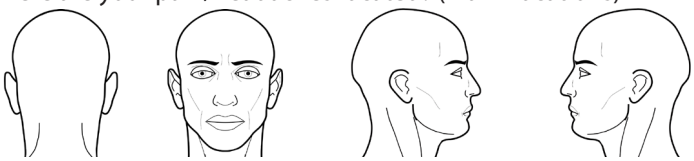
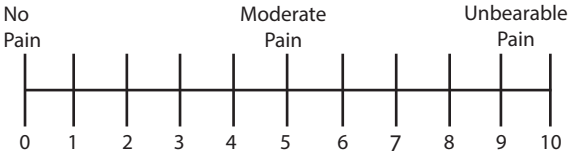
TruDenta®

PAIN/HEADACHE HISTORY

PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

Please review and answer all parts of each question with our staff. Provide specific details/notes in the right hand column.

#	QUESTIONS
1	Have you been diagnosed by a health care provider with any of the following? » ☐ Migraine » ☐ Chronic Daily Headache » ☐ Tension Headache » ☐ Cluster Headache » ☐ Medication Overuse Headache » ☐ Menstrual Migraine » ☐ Trigeminal Neuralgia » ☐ Fibromyalgia » ☐ TMJ/D » ☐ Neck Problems » ☐ Other _____
2	What sets off or triggers your pain or headaches? _____
3	What tests have you had to help diagnose your headaches? » ☐ MRI » ☐ CT Scan » ☐ Blood Tests » ☐ Hormone Testing
4	Where are your pain/headaches located? (Mark Locations)  Back Front Right Side Left Side On a scale of 1-10, how painful is it? 
5	Describe the type of headache pain you feel most often: » ☐ Achy » ☐ Throbbing » ☐ Stabbing » ☐ Other _____
6	What other doctors have you seen for your pain, headaches, and/or migraines

☐ GP / FAMILY DOCTOR / OB-GYN	_____	☐ PHYSICAL THERAPIST	_____
☐ DENTIST (IF OTHER)	_____	☐ CHIROPRACTOR	_____
☐ NEUROLOGIST	_____	☐ EAR NOSE THROAT	_____
☐ PSYCHIATRIST/PSYCHOLOGIST	_____	☐ OTHER	_____

7 What medications do you use for headache, migraine, or pain relief?

MEDICATION (NAME OF MEDICATION OR SUBSTANCE)	WHAT DOSE?	HOW OFTEN?
Acetaminophen, Tylenol		
Ibuprofen, Advil, Motrin, Nuprin, etc..		
Naproxin, Aleve		
Rx pain medication ( )		
Rx pain medication ( )		
Rx muscle relaxant ( )		
Rx anxiety medication ( )		
Rx depression medication ( )		
Rx migraine medication ( )		
Medication for sleeping ( )		
Caffeine intake ( )		
Alcohol intake ( )		
THC, Medical Marijuana ( )		
Other: ( )		

8 Do you try non-medicating techniques for managing your pain or headaches? ☐ Yes ☐ No

» ☐ Yoga » ☐ Breathing Exercises » ☐ Cold Packs » ☐ Massage » ☐ Meditation » ☐ Physical Therapy » ☐ Hot Packs/ Hot Bath

» ☐ Acupuncture » ☐ Exercise » ☐ Other (please describe) _____

I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION BEST DESCRIBES THE TREATMENTS AND MEDICATIONS I HAVE USED TO HELP ALLEVIATE MY HEADACHES/MIGRAINES/PAIN.

PATIENT SIGNATURE: _____