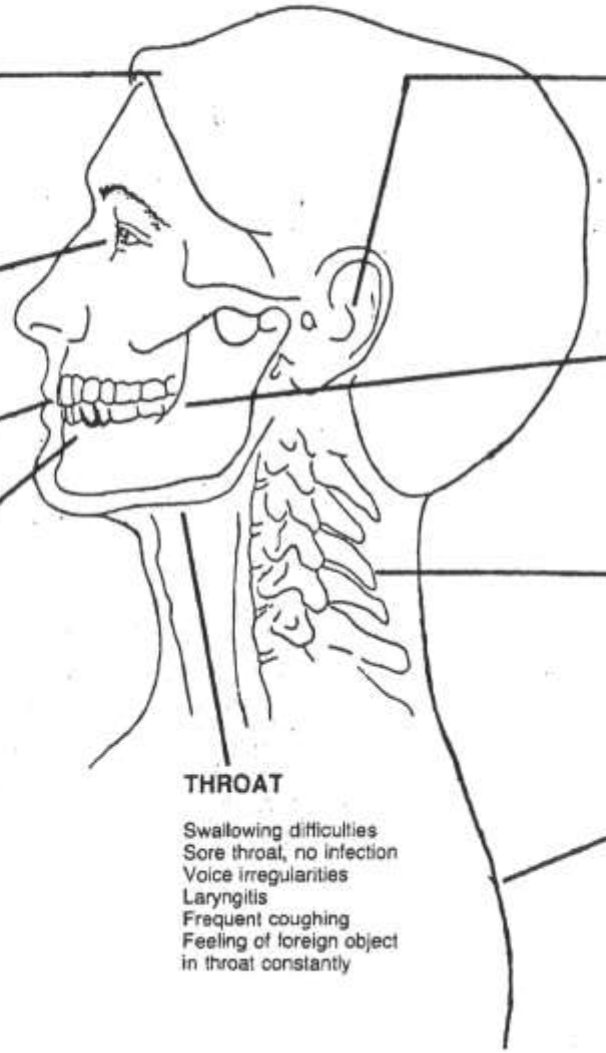
ADDITIONAL HISTORY AND SYMPTOM RESUME

Name _____ Date: _____

Please read carefully and circle only symptoms that apply. Then put the appropriate number after each pertinent item. 1 = mild; 2 = moderate; 3 = severe.



HEADACE, HEAD PAIN

Forhead
Scalp, hair
Temples
Migraine type
Sinus type
Back of head
  shooting pain
  throbbing pain

EYES

Pain behind eye
Bloodshot eyes
Bulging eyes
Light sensivtive

TEETH

Clenching
Grinding
Looseness of back teeth
Soreness of any teeth

MOUTH

Discomfort
Unable to open
Locks shut
Locks open
Limited opening
Jerky opening
Devalted opening
Can't find bite

THROAT

Swallowing difficulties
Sore throat, no infection
Voice irregularities
Laryngitis
Frequent coughing
Feeling of foreign object
in throat constantly

EAR PROBLEMS

Hissing; buzzing
Ringing, tinnitus
Reduced hearing
Ear ache
Pain, no infection
Clogging, itching
Dizziness

JAW PROBLEMS

Clicking
Popping
Grating, crepitus
Muscle pain
Uncontrolled jaw movements
Difficult control of tongue

NECK

Lack of mobility
Stiffness
Throbbing pain
Dull pain
Sore muscles
Tired muscles

BACK, APPENDAGES

Sholder aches
Back aches
Arm or finger numbness
Cold clammy hands