Orofacial Pain Center
Naval Postgraduate Dental School
Navy Medicine Manpower Personnel,
Training and Education Command
8901 Wisconsin Ave

Bethesda, MD 20889
Com (301)295-1495 or 295-6832
DSN 295-1495 or 295-6832
FAX (301)295-2070

Orofacial Pain Examination Form

Oct 2014

Please complete pages 1-8 and circle choices whenever available.

Name _____ Exam Date_____

Sponsor SSN _____ DOB _____ Gender: M F

Active Duty / Retired / Family member Age_____ Ethnicity_____

Branch of Service _____ Rank / Rate _____

Phone (H) (_____)_____ (W) (_____)_____ (Cell) (____)_____

Address _____

City _____ State _____ Zip _____

Email _____

Are you enrolled in? TRICARE Prime TRICARE Extra TRICARE Standard Medicare

Do you have other Insurance? Y N Insurance Company _____

Insurance Policy Number _____

The provider who referred you for this evaluation? _____

Is this evaluation for one of the following: Medical/Physical evaluation board

Second opinion

Litigation/legal issue

BP ____/____
Pulse ____
Resp ____
CO2 ____
HRV ____

Name _____

Why are you here? Describe your pain or problem(s):

_____

_____

_____

When and how did your pain /problem(s) start? _____

_____

_____

Who have you seen for your pain /problem(s)? Please circle**:** Dentist, Primary Care Provider, Neurology, ENT, Pain Clinic, Physical Therapy, Chiropractor, Other

_____

_____

_____

What treatments and//or medications have you received for you pain problem(s)?

_____

_____

Circle the word(s) that describe your pain or problem(s)?

Sharp Burning Electric-like Aching Throbbing Dull Pulsing Pressing Stabbing Tingling

What is your level of pain from <u>the painful area that is the main reason for your visit</u>?

Please mark your pain level on the lines below.

	No discomfort	Worst pain imaginable
1. Today	0_____	10
2. At its Worst	0_____	10
3. On Average	0_____	10

Any pain free days? Yes No When were you last completely pain free? _____

Please Rate Your Pain Interference

4. In the past 6 months, how much has your pain interfered with your daily activities?

No Interference Unable to perform any activities
0_____10

5. In the past 6 months, how much has your pain changed your ability to take part in recreational, social and family activities?

No Interference Unable to perform any activities
0_____10

6. In the past 6 months how much has your pain interfered with your ability to work including housework?

No Interference Unable to perform any activities
0_____10

7. About how many days, in the last six months, have you been kept from your usual activities (work, school and/or housework) because of your pain?
_____

What does your pain limit you from doing?
_____

_____

_____

Pain Modifiers:

What starts your pain? _____

What makes your pain worse? _____

What makes your pain better? _____

Does anything else happen when your pain is present (swelling, change in vision, nausea, etc.)? _____

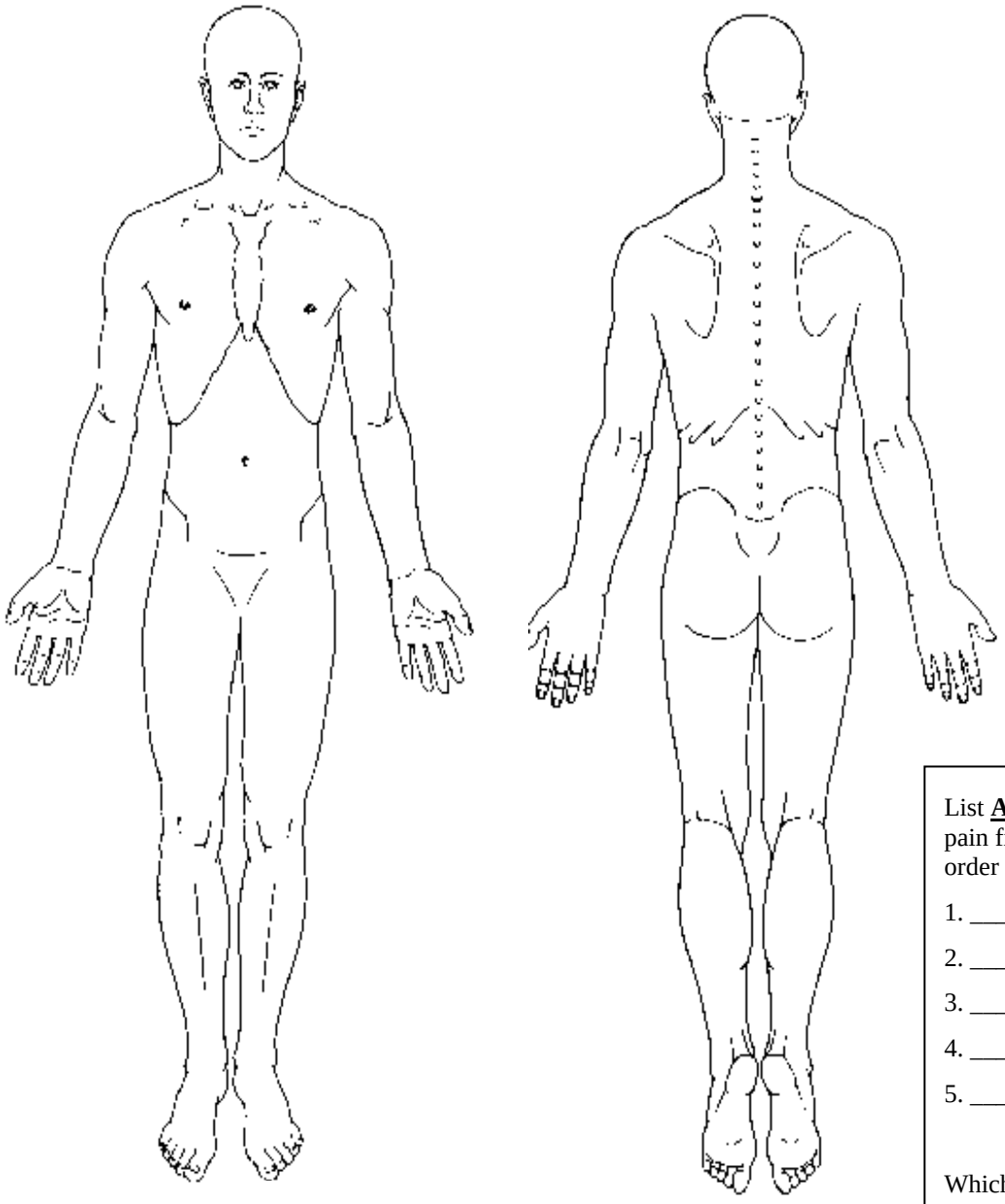
_____

What do you think is wrong or causing your pain/problem (s) and what do you think needs to be done about it?
_____

_____

Why did you decide to seek care at this time? _____
_____

Outline/draw the location(s) of **ANY AND ALL BODY PAIN** that you are experiencing.



Pt 2
Pro

List **ALL** of your pain problems (worst pain first then add others in decreasing order of severity):

1. _____
2. _____
3. _____
4. _____
5. _____

Which pain occurred first?

_____

What is your overall level of total body pain?

Please mark your levels of overall body pain on the lines below.

	No discomfort	Worst pain imaginable
1. Today	0_____	_____10
2. At its Worst	0_____	_____10
3. On Average	0_____	_____10

Any pain free days? Yes No When were you last completely pain free? _____

Medical History

Medical Conditions: _____

_____

Allergies: _____

History of hospitalizations? _____

_____

History of injury or trauma? Yes No _____

Have you ever had a traumatic brain injury (TBI) or a concussion? Yes No

If yes, when? _____ how did itoccur?_____

If yes, did it happen on a military deployment? Yes No

Current prescription medications: _____

_____

Current non-prescription medications: _____

Herbal/Dietary supplements and Vitamins: _____

History of family medical conditions (parents, siblings, etc.)? _____

Personal Information

Nicotine Y N How long? _____ cigarettes _____/day cigars_____ pipe _____ snuff _____

Alcohol Y N beer ____ /day wine _____ glasses/day liquor ____ drinks/day

Caffeine Y N cups(cans)/day _____ coffee tea soda chocolate

Water Y N _____ glasses or bottles/day

Do you skip any meals? Yes No Which? Breakfast Lunch Dinner

Weight: _____lbs Height: ____ft___inches Neck size:____inches Any recent weight gain/loss? Yes No

Exercise level: None Slight Moderate Active Any activity limitations? Yes No

Please estimate how many hours a day (0 to 24 hours) that your teeth touch in any contact. _____

Do you clench or grind your teeth? Yes No Don't know

If yes, how do you know? self-aware told by dentist told by others

Do you? bite your nails chew gum protrude tongue hold the tongue to the roof of the mouth
other habits: _____

Please rate your levels of:

	None		Worst possible
Stress	0	_____	10
Anxiety	0	_____	10
Depression	0	_____	10
Anger	0	_____	10

Have you ever thought of harming yourself? Yes No

Personal/Family History

Occupation: _____

Marital status: Single Married Separated Divorced

Children: Y N If yes, list ages _____

Are there any special needs or circumstances involving you, your family members or your job? Yes No

_____

_____

Do you have any history of the following or similarly threatening, stressful or frightening life events? Yes No

Abuse - at any age (physical, emotional or sexual), childhood neglect, physical or sexual assault, motor vehicle accident, deployment to a conflict zone, panic attacks, near drowning, other _____

_____

_____

_____

Have you been told that you have post-traumatic stress symptoms (PTSS) or post-traumatic stress disorder (PTSD)?

Yes No If yes, when?_____

Headaches

Do you have problems with headaches? Yes No For how long?

_____

Any family history of headaches? Yes No

Do you have more than one kind of headache? Yes No If yes, how many kinds?_____

Please describe each type of headache you experience.

	#1	#2	#3
Where on your head does the headache occur?			
Average pain level 0 (no pain) to 10 (worst ever)			
How often do they occur? (daily, weekly, monthly)			
When do they occur? (morning, evening, etc.)			
How long do they last? (secs, mins, hours, days)			
What starts (triggers) your headache?			

With your headache, do you experience? nausea vomiting light sensitivity sound sensitivity

dizziness aura(altered sensations)

other _____

Do you experience any of the following?

Neck pain? Yes No _____ Neck sounds? Yes No _____

If yes, when did it start? _____ When is it the worst? _____

Pain from areas below your shoulders? Yes No If yes, where? _____

Dizziness or lightheadedness? Yes No _____

Ear problems? Yes No fullness stuffiness ringing sounds pain _____

Numbness or tingling? Yes No around mouth head/face arms/fingers legs/toes other _____

Jaw pain? Yes No_____

Tooth pain? Yes No _____

Changes in your bite? Yes No_____

Altered jaw movement(s)? Yes No _____

Jaw joint (TMJ) sounds? Yes No If yes, is it? popping clicking grating/grinding other _____

Did jaw joint (TMJ) sounds begin before your pain started? Yes No unsure

Have there been any changes in the jaw sounds? _____

If you have jaw pain or stiffness, when is it the worst? with awakening morning noon afternoon evening

Does your jaw problem affect your ability to eat? Yes No _____

Sleep History

How many hours do you sleep? Average night _____Good night _____ Bad night _____

How long does it take to fall asleep? Average night _____Good night _____Bad night _____

Do you have a regular/consistent sleep schedule? Yes No _____

Do you snore or have a history of sleep apnea? Yes No _____

Do you sleep using a CPAP &/or an oral device for sleep apnea? Yes No _____

Is your obstructive sleep apnea mild moderate severe

What position do you fall asleep in? side back stomach

Do you have problems with nightmares? Yes No If yes, are they recurring? Yes No

What are the words that best describe your sleep? Good Fair Poor Sound Light Restless

Do you consider your sleep to be restful or restorative? Yes No _____

Please check the most appropriate box concerning your sleep during the last 4 weeks.

	No, not in last 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4times a week	Yes, 5 or more times a week
Did you have trouble falling asleep?					
Did you wake up several times a night?					
Did you wake up earlier than you planned?					
Did you have trouble getting back to sleep after you woke up too early?					

Please list any additional information that you feel is important for us to know about you, your pain complaint or other aspects of your visit.

_____

_____

_____

_____

_____

Exam Form Part II

Revised Oct 2014

Patient Summary

History of Present Complaint(s):

Description of Pain Complaint(s):

Pain Complaint	**Primary**	**Secondary**	**Tertiary**
Location			
Onset			
Character (quality)			
Intensity (0-10)			
Frequency (daily, weekly, etc.)			
Duration (secs, mins, hrs, days)			
Initiating Factors			
Aggravating Factors			
Alleviating Factors			
Associated Symptoms			

Medical History:
(Meds, Allergies, Hospitalizations, Trauma, etc.)

Family Medical History:
(Parents, Siblings, etc.)

Review of Systems:
(CV, Neuro, GI, ENT, etc.)

Psych/Social History:
(Depression, Anxiety, Stressors, Job, Family Status, etc.)

Habits:
(Smoking, Alcohol, Parafunction, Gum, etc.)

Sleep:

Other:

Characteristic Pain Intensity (CPI) Which pain does this relate to? _____

Intensity #1 ____ + intensity #2 ____ + intensity #3 ____ = _____ /3 = _____ X 10 = _____ **CPI**

Disability

#7 disability days _____ 0-6=0, 7-14=1, 15-30=2, >30=3 **Disability day points** _____

Disability question #4 ____ + Disability question #5 ____ + Disability question #6 ____ = _____ /3 = _____ X 10 = _____ 0-29=0, 30-49=1, 50-69=2, >70=3 **Disability score points** ____

Disability day points _____ + Disability score points ____ = _____ **Disability Points**

Grade I Low Intensity, Low Disability	CPI < 50, Disability Points < 3
Grade II High Intensity, Low Disability	CPI $\geq$ 50, Disability Points < 3
Grade III Moderately Limiting	3-4 Disability Points, any CPI
Grade IV Severely Limiting	5-6 Disability Points, any CPI

EXAMINATION

GENERAL APPEARANCE

Head and Neck (Development, Symmetry) _____ WNL: _____
Overall Body _____ WNL: _____

CRANIAL NERVE SCREENING

(I) Olfactory _____ WNL: _____

(II) Gross Vision _____ WNL: _____

(III, IV, VI) Extra-ocular Muscles _____ WNL: _____

Pupil (Equality, Reaction, Accommodation) _____ WNL: _____

(V) Sensory (V1, V2, V3, C2-T2) _____ WNL: _____

(V) Motor (Function and Symmetry) _____ WNL: _____

(VII) Motor (Facial Muscles) _____ WNL: _____

(VIII) Gross Hearing _____ WNL: _____
External Auditory Canal /Tympanic Membrane _____ WNL: _____

(IX, X) Palatal Elevation/Gag Reflex _____ WNL: _____

(XI) Shoulder Shrug/Lateral Head Movement _____ WNL: _____

(XII) Tongue Protrusion _____ WNL: _____

BALANCE COORDINATION

Gait &Gross Motor Movement _____ WNL: _____
Finger to Nose Movement _____WNL:_____
Heel to Toe Walking Movement _____ WNL: _____

CERVICAL EXAMINATION

Head/ Neck Position ____WNL: Forward head/body Lateral tilt//turn (R L) Rounded shoulders

Rotation (70 degrees)	Right	____ WNL	____ Restricted	____ Pain	R	L
	Left	____ WNL	____ Restricted	____ Pain	R	L
Lateral Tilt (60 degrees)	Right	____ WNL	____ Restricted	____ Pain	R	L
	Left	____ WNL	____ Restricted	____ Pain	R	L
Flexion/Extension	Back	____ WNL	____ Restricted	____ Pain	R	L
	Forward	____ WNL	____ Restricted	____ Pain	R	L

RANGE OF MANDIBULAR MOVEMENT

Incisal opening w/o increasing pain _____mm Maximum incisal opening _____mm

Pain with Max opening ____ No ____ Yes: Location_____Intensity_____/10

Right Lateral Movement ____ No ____ Yes, ____ R ____ L _____ mm

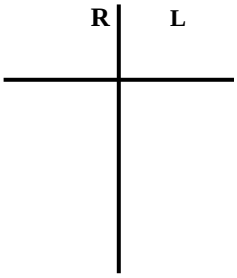
Left Lateral Movement ____ No ____ Yes, ____ R ____ L _____ mm

Protrusive Movement ____ No ____ Yes, ____ R ____ L _____ mm

Any Deflection / Deviation ___No____ Yes ____ R ____ L _____mm

End Feel (with restriction) Hard Soft

Overbite: _____ %/mm Overjet: _____ mm



TMJ SOUNDS

Crepitus: None Right Left Mild Moderate Severe

Click or Pop: None Right Opening Reciprocal Intermittent Painful

None Left Opening Reciprocal Intermittent Painful

Is sound eliminated with protrusion? _____ No _____ Yes

CLENCHING ON BACK TEETH VS TONGUE BLADE TEST

Is there pain when clenching on posterior teeth? ____ No ____ Yes R L

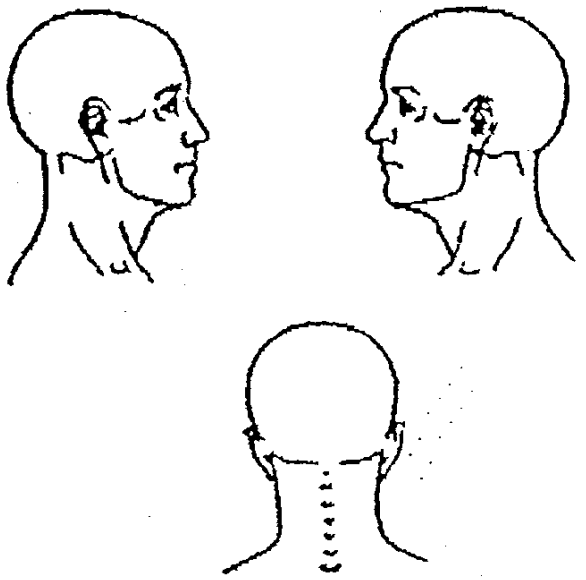
Clenching on tongue blades is?

Anterior:	Better	Same	Worse	R or L
Left:	Better	Same	Worse	R or L
Right:	Better	Same	Worse	R or L
Bilateral:	Better	Same	Worse	R or L

PALPATION EXAM

Codes: 0 = Non Painful, 1 = Tenderness, 2 = Painful, 3 = Pain with withdrawal
T = Trigger Point (draw arrow to depict pattern of referral, if present)
A = allodynia, H = hyperalgesia, ↑ = hypertrophy, ↓ = atrophy

	Right	Left
Rhomboid		
Levator scapula		
Trapezius		
SCM		
Splenius capitis		
Occipitalis		
Paracervical		
C Spine		
Masseter		
Temporalis		
Frontalis		
TMJ (static)		
TMJ (dynamic)		
TMJ (EAC)		
Lateral pterygoid		
Joint loading		
Temporal tendon		
Medial pterygoid		
Anterior digastric		
Posterior digastric		



ORAL EXAMINATION

Acute malocclusions? _____ No _____ Yes When? _____

Soft Tissue (tongue , soft palate, uvula)_____ WNL: _____

Salivary Glands _____ WNL: _____

Lymph Nodes _____ WNL: _____

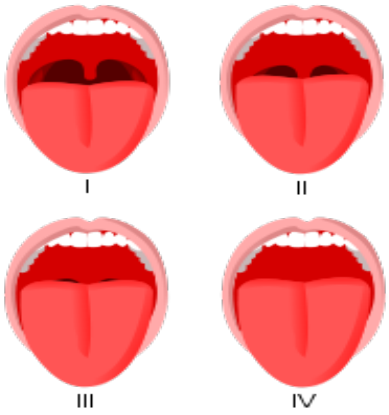
Periodontal Health: _____ WNL: _____

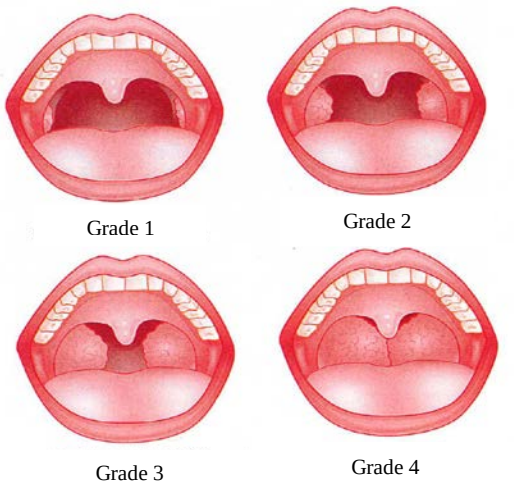
Tooth sensitivity/percussion _____

General description of the dentition: _____
_____

Tooth Wear: Physiologic ____ Moderate ____ Severe ____

Mandibular posturing or tongue thrusting? Yes No _____





Mallampati Classification: _____ Tonsil size grading: _____

Occlusion: Is the occlusion stable? Yes No _____

Class I ____ Class II ____ Div 1 2 Class III ____

Open Bite? Yes No _____

Guidance/Interferences? _____

Splint History: Yes No _____

DIAGNOSTIC TESTS

Radiographs/ Imaging: _____ Not Indicated
____ Panoramic _____
____ TMJ Series _____
____ Intraoral _____
____ Waters _____
____ Townes _____
____ SMV _____
____ Mand. Series_____
____ CAT Scan _____
____ MRI _____
____ Other _____

Laboratory Tests: _____ Not Indicated
____ Erythrocyte Sedimentation Rate
____ Rheumatoid Factor
____ Antinuclear Antibody
____ Bone Scan
____ CBC
____ Diff
____ Other

Anesthetic Blocking: ____ Not Indicated _____ cc of _____ % _____

Location	Time	Max I/O	Comfortable I/O	Pain level
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Procedure	CPT Code	Cost	
New pt, expanded (20)	99202	$166	
New pt, moderate complexity (45)	99204	$363	
New pt, high complexity (60)	99205	$453	
Established pt, expanded (15)	99213	$162	
Established pt, detailed (25)	99214	$239	
Established pt, comprehensive (40)	99215	$320	
Observation/inpt hospital care (25)	99232	$158	
Observation/inpt hospital care (45)	99234	$292	
Prolonged service w/o contact	99358	$240	
Prolonged service w/o contact (ADD)	99359	$116	
Injection, tendon sheath ligament	20550	$90	
Trigger point injection (1 or 2)	20552	$123	
Trigger point injection (3 or 4)	20553	$143	
Muscle testing, extremity or trunk	95831	$62	
Range of motion measurements	95851	$41	
Biofeedback training	90901	$91	
Application of hot or cold packs	97010	$13	
Application of electric stimulation	97032	$43	
Ultrasound one or more areas	97035	$29	
Manual therapy, myofascial release	97140	$68	
Prevent. med ind. counseling (15)	99401	$81	
Exercises, develop range of motion	97110	$73	
Neuromuscular reeducation	97112	$76	
Acupuncture, w/o stim, 15 min	97810	$80	
Acupuncture, w/o stim, (ADD 15 min)	97811	$60	
Acupuncture w stim, 15 min	97813	$86	
Acupuncture, w stim (ADD 15 min)	97814	$69	

Procedure	ADA code	Cost	
Detailed, extensive evaluation	D0160	$95	
Problem focused re-evaluation	D0170	$62	
Pall (Emerg) tx: dental pain	D9110	$87	
Local anesth not conj w opr/surg	D9210	$33	
Regional block anesthesia	D9211	$36	
Trigeminal div block anesthesia	D9212	$58	
Therapeutic drug injection	D9610	$47	
Pulp vitality tests	D0460	$47	
Behavior management (1/15min)	D9920	$85	
Nutrition counseling	D1310	$39	
Tobacco counseling	D1320	$43	
Individual OHI	D1330	$41	
Other drugs/ meds	D9630	$26	
Occlusal orthotic device	D7880	$592	
Sleep apnea device	A7881	$1,197	
Athletic mouth guard	D9941	$144	
Repair/ reline occlusal guard	D9942	$127	
Occlusal adjustment, limited	D9951	$85	
Diagnostic casts	D0470	$80	
Oral/ facial photography	D0350	$47	
Patient seating	A9999	$0	
Imaging			
Panorex	D0330	$99	
Intraoral first image	D0220	$25	
Intraoral, each additional image	D0230	$21	
Occlusal image	D0240	$38	

Patient Name: _____ Last 4 SSN_____

Provider: _____ Status:_____

Date: _____ Oct 2014

Wounded warrior: Yes No

Co-morbidities:

Combat TBI PTSD IBS GERD Anxiety

Abuse/Assault IC FM CFS OSA Panic Depression

Diagnosis: (Number 1 – 5 as applicable, where 1 is the primary diagnosis)

Atypical facial pain	TMJ arthralgia
Glossodynia	Disc displacement with reduction
Trigeminal nerve disorder	Disc displacement without reduction
Disorders of other cranial nerves	Osteoarthritis
	Subluxation
Cluster Headache	
Headache	Sleep apnea
Hemicrania	Sleep disturbance
Migraine with aura	Sleep disorder
Migraine without aura	
Tension type headache	Bruxism
	Cervicalgia
Myalgia (facial, cervical)	Fibromyalgia
Cervical MFP	Otalgia
Masticatory MFP	Reaction to chronic stressors
Non-neutral head and neck posture	
Protective co-contraction	