



Symptom Check List

Patient Name _____ Date _____

Please check any of the following symptoms which may apply to you.

Headaches

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Tension Headaches | |
| <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> How Often? _____ | | |
| <input type="checkbox"/> Top of Head | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Forehead | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Back of Head
(occipital) | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Temples | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Behind Eyes | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Pain in Neck | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Pain in Ear | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Dizziness
(vertigo) | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Pain in jaw Joint | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Clicking or Popping
Sound in Joint | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Pain in shoulder | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Ear congestion | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Tinnitus
(ringing sound in ears) | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Facial Pain
(nonspecific) | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |
| <input type="checkbox"/> Grating sound in
Joint | <input type="checkbox"/> Left Side | <input type="checkbox"/> Right Side |

Occlusal Habits

- | | | |
|---|-----------------------------|-----------------------------|
| <input type="checkbox"/> Clenching | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
| <input type="checkbox"/> Grinding on teeth | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
| <input type="checkbox"/> Teeth hit in front first | | |
| <input type="checkbox"/> Gum chewing | | |
| <input type="checkbox"/> Pencil biting | | |
| <input type="checkbox"/> Cheek biting | | |
| <input type="checkbox"/> Pipe smoking | | |
| <input type="checkbox"/> Nail biting | | |
| <input type="checkbox"/> Other _____ | | |

Postural Habits

- | |
|---|
| <input type="checkbox"/> Phone cradling |
| <input type="checkbox"/> TV watching |
| <input type="checkbox"/> Shoulder bag |
| <input type="checkbox"/> Leans chin on hand |
| <input type="checkbox"/> Heavy lifting |
| <input type="checkbox"/> Pipe smoking |
| <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Other _____ |

Additional Comments

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| Partial inability to open mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Face Muscle twitch | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty swallowing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty breathing through nose | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty chewing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |