THE HEAD AND NECK CENTERS OF EXCELLENCE
SPECIALIZED CARE IN HEAD, NECK & TMJ COMPLAINTS

The Head & Neck Centers Of Excellence Patient Qualification Intake Form

Welcome to The Head & Neck Centers Of Excellence. In order to accurately assess you and to determine if you are a true candidate for our care, it is important that you fill out this form as thoroughly as possible. Thank You.

Today's Date _____
Name _____ Age _____ Birthday _____ Sex M F
Address _____
City_____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Best Place to Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? Yes No
Employer _____ Occupation_____ Length of Employ_____
Marital Status S M W D Spouses Name _____

How Did You Hear About The Head & Neck Centers Of Excellence _____
How Serious Do You Think Your Problem Is? _____

What Is Your Main Problem/Symptom Prompting Your Request for A Consultation with the Doctor?
_____

Would You Consider This Problem (circle one). MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitations)
SEVERE (Causing Significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

1. In spite of the fact that you are not a specialist, you are in fact the person who knows more about your pain than anyone else. In your own words and in your own opinion what do you think the real problem is?

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2. What are you hoping happens today as a result of your consultation with the Doctor?

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3. Since your pain became this severe what three things has it caused you to miss the most?

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3. How long have you been like this?

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4. How has your life changed since your condition became a problem?

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5. What activities are you limited in?

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6. What kinds of treatments have you received?

Physical Therapy: How Long _____ When(approx) _____
Medication: _____ When(approx) _____
Surgery: Type_____ When(approx) _____
Other_____

7. When did you receive these treatments and for how long?

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8. Did any of these treatments work? If so which one(s)? For how long?

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9. Is there anything you can do that makes it feel better?

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10. What activities/movements are guaranteed to make it worse?

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11. Please describe the quality of the pain. (Sharp, Dull, achy, toothache, shooting, stabbing, numb, tingling, etc...)

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12. Is it worse in the morning or is it worse as the day progresses?

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13. If you cannot find a solution to this problem what do you think will happen to you?

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14. Describe what will be different in your life if you can get better.

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15. When is the VERY FIRST time you recall having this problem?

List In Order Of importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above.
1._____ How Long Have You Had This?_____
2._____ How Long Have You Had This?_____
3._____ How Long Have You Had This?_____
4._____ How Long Have You Had This?_____

In Reference To Your MAIN PROBLEM How Often Are You Aware of This Problem? (circle one)
Occasionally (25% of the time)
Intermittently (50% of the time)
Frequently (75% of the time)
Constant (90-100% of the time)

Due To Your Main Problem.....
Have You Lost Any Time From Work? Yes No
How Much Time and What Tasks Have Been Limited? _____
Have You Lost Any Time From Your Chores/Tasks At Home? Yes No
How Much Time and What Tasks Have Been Limited? _____
Have You Lost Any Time From Your Family? Yes No
How Much Time and What Tasks Have Been Limited? _____
Have You Lost Any Time From Your Leisure Activities? (Hobbies, Travel, Sports, etc...)
How Much Time and What Tasks Have Been Limited? _____
Considering the amount of pain/discomfort you've had THIS week, how long has your problem been this severe?
_____

On a Scale of 0-10 (10 being unbearable, 0 being No Pain or Discomfort) Please rate the following...
The HIGHEST your pain gets WITHOUT medication _____
The LOWEST your pain gets WITHOUT medication _____
The HIGHEST your pain gets WITH medication _____
The LOWEST your pain gets WITH medication _____
List ANY surgeries that you have had and the corresponding dates.

Signature: _____ Date: _____

Thank You.
You will be seen shortly with one of our doctors.
In the meantime, if there is anything that we can do to make you more comfortable,
Please don't hesitate to ask.