

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date: \_\_\_\_\_

*Please circle any symptoms you may have.*

**HEAD/FACE**

1. Forehead pain
2. Temporal pain
3. Tension headaches
4. Migraine headaches
5. Sinus headaches
6. Back of head headaches
7. Hair/scalp tender to touch

**EAR**

1. Ear pain without infection
2. Decreased hearing
3. Clogged, itchy or stuffy ears
4. Ringing, buzzing
5. Dizziness
6. Balance problems

**THROAT**

1. Swallowing difficulties
2. Feeling of foreign object in throat
3. Sore throat without infection
4. Voice changes
5. Laryngitis
6. Frequent coughing or clearing

**JAW**

1. Jaw pain
2. Jaw joint pain
3. Clicking/popping jaw joint
4. Grating sound in jaw joint
5. Pain in cheek muscles
6. Uncontrollable jaw movements
7. Jaw locks open/shut
8. Deviates to one side on opening or closing

**NECK**

1. Lack of mobility
2. Stiffness
3. Neck pain
4. Tired/sore neck muscles
5. Shoulder pain
6. Back pain: middle, lower
7. Arm/finger pain/numbness

**EYES**

1. Pain in/around eyes
2. Bloodshot eyes
3. Sensitive to light
4. Tearing of eyes
5. Blurred vision
6. Pressure behind eye

**MOUTH**

1. Abnormal opening
2. Limited opening
3. Bad bite
4. Missing teeth
5. Excessive mouth breathing
6. Clench or grind teeth
7. Mouth discomfort
8. Inability to find "bite"

**NASAL**

1. Sinus pain
2. Sinus problems
3. Post nasal drainage
4. Allergies