

## PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

#	DENTAL FOUNDATION (TEETH, MUSCLES, JOINTS)		#	SYMPTOMS
1	Have you noticed a change in the way your teeth fit together? » If 'Yes', it is because of <input type="checkbox"/> Dental Changes <input type="checkbox"/> Trauma <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	13	Do you experience pain in » Jaw <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> More than 1 year » Face <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> More than 1 year » Neck <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> More than 1 year » Shoulders <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> More than 1 year » Arms <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> More than 1 year
2	Where do you think your teeth hit or fit first? » More on the: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Equal » More on the: <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Equal		14	Do you experience ringing or fullness in your ears? <input type="checkbox"/> Yes <input type="checkbox"/> No » Which one? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
3	Do your jaw muscles get tight or sore? » When? <input type="checkbox"/> Morning <input type="checkbox"/> Evening <input type="checkbox"/> After chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No	15	How often do you get headaches that make it difficult to function without medication? <input type="checkbox"/> Almost Daily <input type="checkbox"/> More than once a week <input type="checkbox"/> More than once a month <input type="checkbox"/> Almost never
4	Do you have pain or difficulty opening wide?	<input type="checkbox"/> Yes <input type="checkbox"/> No	16	How often do you get other milder headaches? <input type="checkbox"/> Almost Daily <input type="checkbox"/> More than once a week <input type="checkbox"/> More than once a month <input type="checkbox"/> Almost never
5	Are you aware of noises in your jaw joints? <input type="checkbox"/> Popping <input type="checkbox"/> Clicking <input type="checkbox"/> Other » Where? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both » How long? <input type="checkbox"/> Less than 1 year <input type="checkbox"/> More than 1 year	<input type="checkbox"/> Yes <input type="checkbox"/> No	17	Have your headaches changed in the last six months? <input type="checkbox"/> About the same <input type="checkbox"/> Slight worsening <input type="checkbox"/> Same but more frequent <input type="checkbox"/> Somewhat less <input type="checkbox"/> A lot worse  Got less/worse when _____
CAUSES & COMPLICATIONS			IMPACT ON DAILY LIVING ACTIVITIES	
6	Do you grind or clench your teeth? » Do you wear a? <input type="checkbox"/> Splint <input type="checkbox"/> Night Guard <input type="checkbox"/> Retainer <input type="checkbox"/> NTI <input type="checkbox"/> Sleep Appliance	<input type="checkbox"/> Yes <input type="checkbox"/> No	18	What is your stress level? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
7	Have you had any significant dental treatments? <input type="checkbox"/> Orthodontics <input type="checkbox"/> Oral surgery / wisdom teeth removal <input type="checkbox"/> Long dental appointments <input type="checkbox"/> Tooth Loss <input type="checkbox"/> Crowns	<input type="checkbox"/> Yes <input type="checkbox"/> No	19	What is your anxiety level? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
8	Have you been in a motor vehicle accident, major or minor? » How many? _____ » When was the last accident? <input type="checkbox"/> 0-3 Months <input type="checkbox"/> 3-12 Months <input type="checkbox"/> More than 1 year » Did you hit your head? <input type="checkbox"/> Head Injury <input type="checkbox"/> Whiplash <input type="checkbox"/> Concussion <input type="checkbox"/> Car <input type="checkbox"/> ATV <input type="checkbox"/> Motorcycle <input type="checkbox"/> Bicycle <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	20	What have you missed out upon because of your pain or headaches? (Check all that apply) <input type="checkbox"/> Days at work <input type="checkbox"/> Focus at work <input type="checkbox"/> Activities with friends/family <input type="checkbox"/> Activities with children <input type="checkbox"/> Household chores <input type="checkbox"/> Major events
9	Have you had other head/neck trauma? <input type="checkbox"/> Slip/Fall <input type="checkbox"/> Sports Injury <input type="checkbox"/> Trauma <input type="checkbox"/> Fights/Domestic Violence <input type="checkbox"/> Other » When? <input type="checkbox"/> 0-3 Months <input type="checkbox"/> 3-12 Months <input type="checkbox"/> More than 1 year » Type of injury <input type="checkbox"/> Head Injury <input type="checkbox"/> Concussion <input type="checkbox"/> Whiplash <input type="checkbox"/> Neck Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	21	When you have pain, headaches or migraines, how does that make you feel? (Check all that apply) <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Tired or exhausted <input type="checkbox"/> Frustrated <input type="checkbox"/> Guilty <input type="checkbox"/> Ashamed <input type="checkbox"/> Relationship tension <input type="checkbox"/> Other _____
10	Do you have any postural position problems? <input type="checkbox"/> Working at a desk <input type="checkbox"/> Sitting at work <input type="checkbox"/> Computer/laptop <input type="checkbox"/> Commuting	<input type="checkbox"/> Yes <input type="checkbox"/> No	22	How many days per month are you:  Pain Free? _____  Headache Free? _____
11	Daytime sleepiness, drowsiness, or tiredness?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
12	Problems with sleep? » Insomnia <input type="checkbox"/> Yes <input type="checkbox"/> No » Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No » Sleep Disturbances <input type="checkbox"/> Yes <input type="checkbox"/> No » Less than 7 hours per night <input type="checkbox"/> Yes <input type="checkbox"/> No » Other _____			<b>NOTES:</b> _____ _____ _____ _____