

PATIENT INFORMATION

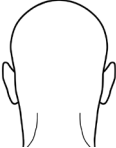



NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

#	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? <input type="checkbox"/> More on the right <input type="checkbox"/> Left <input type="checkbox"/> Equal <input type="checkbox"/> More on the 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 severe headaches/migraines that makes it difficult to function without treatment or medication? <input type="checkbox"/> Occasionally <input type="checkbox"/> More than twice a year <input type="checkbox"/> More than once a month <input type="checkbox"/> More than once a week <input type="checkbox"/> 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"/> Daily <input type="checkbox"/> More than 3 per week <input type="checkbox"/> More than 2 per month <input type="checkbox"/> Other _____
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"/> A lot worse Got 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"/> 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"/> Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	19	Do you have anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
8	Have you been in a car accident, major or minor? » How many? _____ » When was the last accident? <input type="checkbox"/> 0-6 Months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> More than 1 year » Did you see the accident coming? <input type="checkbox"/> Yes <input type="checkbox"/> No » Did the airbag deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20	Because of pain, headaches or migraines, in the last month: # Of days you could not go to school _____ # Of days you did reduced amount of work _____ # Of days you could not do usual household work/parenting _____ # Of days you missed family or social functions _____
9	Have you had sports injuries and/or trauma to your head & neck? » When? <input type="checkbox"/> Less than 1 year <input type="checkbox"/> More than 1 year	<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 work at a desk, computer or in a forward head posture position? » Do you have any other postural position problems? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	NOTES: _____ _____ _____ _____	
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 _____				

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Please review and answer all parts of each question with our staff. Provide specific details/notes in the right hand column.

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4	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Where are your headaches located? (Mark Locations)</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;">  Back </div> <div style="text-align: center;">  Front </div> <div style="text-align: center;">  Right Side </div> <div style="text-align: center;">  Left Side </div> </div> </div> <div style="width: 50%;"> <p>On a scale of 1-10, how painful are your headaches/migraines?</p> <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;">No Pain</div> <div style="flex-grow: 1; border-bottom: 1px solid black; position: relative;"> <div style="position: absolute; top: -10px; left: 0; right: 0; text-align: center;">Moderate Pain</div> <div style="position: absolute; top: -10px; right: 0; text-align: center;">Unbearable Pain</div> </div> <div style="margin-left: 10px;">0 1 2 3 4 5 6 7 8 9 10</div> </div> </div> </div>																																													
5	<p>Describe the type of headache pain you feel most often:</p> <p>» <input type="checkbox"/> Achy » <input type="checkbox"/> Throbbing » <input type="checkbox"/> Stabbing » <input type="checkbox"/> Other _____</p>																																													
6	<p>What other doctors have you seen or tests have you had for your pain headaches, and/or migraines</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> GP / FAMILY DOCTOR _____ <input type="checkbox"/> DENTIST (IF OTHER) _____ <input type="checkbox"/> ORAL/MAXILLOFACIAL SPECIALIST _____ <input type="checkbox"/> PSYCHIATRIST/PSYCHOLOGIST _____ </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> PHYSICAL THERAPIST _____ <input type="checkbox"/> CHIROPRACTOR _____ <input type="checkbox"/> MRI/CT SCAN/BLOOD WORK _____ <input type="checkbox"/> OTHER _____ </td> </tr> </table>	<input type="checkbox"/> GP / FAMILY DOCTOR _____ <input type="checkbox"/> DENTIST (IF OTHER) _____ <input type="checkbox"/> ORAL/MAXILLOFACIAL SPECIALIST _____ <input type="checkbox"/> PSYCHIATRIST/PSYCHOLOGIST _____	<input type="checkbox"/> PHYSICAL THERAPIST _____ <input type="checkbox"/> CHIROPRACTOR _____ <input type="checkbox"/> MRI/CT SCAN/BLOOD WORK _____ <input type="checkbox"/> OTHER _____																																											
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7	<p>What medications do you use for headache, migraine, or pain relief?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:40%;">MEDICATION (NAME OF MEDICATION OR SUBSTANCE)</th> <th style="width:30%;">WHAT DOSE?</th> <th style="width:30%;">HOW OFTEN?</th> </tr> </thead> <tbody> <tr><td>Acetaminophen, Tylenol</td><td></td><td></td></tr> <tr><td>Ibuprofen, Advil, Motrin, Nuprin, etc..</td><td></td><td></td></tr> <tr><td>Naproxin, Aleve</td><td></td><td></td></tr> <tr><td>Rx pain medication ()</td><td></td><td></td></tr> <tr><td>Rx pain medication ()</td><td></td><td></td></tr> <tr><td>Rx muscle relaxant ()</td><td></td><td></td></tr> <tr><td>Rx anxiety medication ()</td><td></td><td></td></tr> <tr><td>Rx depression medication ()</td><td></td><td></td></tr> <tr><td>Rx migraine medication ()</td><td></td><td></td></tr> <tr><td>Medication for sleeping ()</td><td></td><td></td></tr> <tr><td>Caffeine intake ()</td><td></td><td></td></tr> <tr><td>Alcohol intake ()</td><td></td><td></td></tr> <tr><td>THC, Medical Marijuana ()</td><td></td><td></td></tr> <tr><td>Other: ()</td><td></td><td></td></tr> </tbody> </table>	MEDICATION (NAME OF MEDICATION OR SUBSTANCE)	WHAT DOSE?	HOW OFTEN?	Acetaminophen, Tylenol			Ibuprofen, Advil, Motrin, Nuprin, etc..			Naproxin, Aleve			Rx pain medication ()			Rx pain medication ()			Rx muscle relaxant ()			Rx anxiety medication ()			Rx depression medication ()			Rx migraine medication ()			Medication for sleeping ()			Caffeine intake ()			Alcohol intake ()			THC, Medical Marijuana ()			Other: ()		
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8	<p>Do you try non-medicating techniques for managing your headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>» <input type="checkbox"/> Yoga » <input type="checkbox"/> Breathing Exercises » <input type="checkbox"/> Cold Packs » <input type="checkbox"/> Massage » <input type="checkbox"/> Meditation » <input type="checkbox"/> Physical Therapy</p> <p>» <input type="checkbox"/> Other (please describe) _____</p>																																													