



## PATIENT INFORMATION

NAM	Ε   [	DATE			AGE SEX TELEPHONE
	1	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 □ Dental Changes □ Trauma □ Other	□ Yes	□ No	13	Do you experience pain in  » Jaw Right Left Both More than 1 year  » Face Right Left Both More than 1 year  » Neck Right Left Both More than 1 year  » Shoulders Right Left Both More than 1 year  » Arms Right Left Both More than 1 year
2	Where do you think your teeth hit or fit first?  ☐ More on the right ☐ Left ☐ Equal ☐ More on the front ☐ Back ☐ Equal			14	Do you experience ringing or fullness in your ears?  ☐ Yes ☐ No  » Which one? ☐ Right ☐ Left ☐ Both
3	Do your jaw muscles get tight or sore?  » When?   Morning   Evening   After chewing	□ Yes	□ No	15	How often do you get severe headaches/migraines that makes it difficult to function without treatment or medication?  □ Occasionally □ More than twice a year □ More than once a month □ More than once a week □ Never
4	Do you have pain or difficulty opening wide?	□ Yes	□ No	16	How often do you get other milder headaches?  □ Daily □ More than 3 per week □ More than 2 per month  □ Other □
5	Are you aware of noises in your jaw joints?  Popping Clicking Other  Where? Right Left Both  How long? Less than 1 year More than 1 year	□ Yes	□ No	17	Have your headaches changed in the last six months?  About the same Slight worsening Same but more frequent  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? □ Splint □ Night Guard □ Retainer	□ Yes	□ No	18	What is your stress level? □ Mild □ Moderate □ Severe
7	Have you had any significant dental treatments?  Orthodontics Oral surgery / wisdom teeth removal Long dental appointments Other	□ Yes	□ No	19	Do you have anxiety?
8	Have you been in a car accident, major or minor?  **How many?  **When was the last accident?	□ Yes	□ 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? □ Less than 1 year □ More than 1 year	□ Yes	□ No	21	When you have pain, headaches or migraines, how does that make you feel? (Check all that apply)  Angry Depressed Tired or exhausted Frustrated Guilty Ashamed Relationship tension Other
10	Do you work at a desk, computer or in a forward head posture position?  » Do you have any other postural position problems?	□ Yes	□ No	22	How many days per month are you:  Pain Free?
11	Daytime sleepiness, drowsiness, or tiredness?	□ Yes	□ No		Headache Free?
12	Problems with sleep?  » Insomnia				NOTES: