



Comprehensive Health Questionnaire

Demographic Information

Mr. Ms. Miss Mrs. Dr.

First Name: _____ Middle Initial: _____ Last Name: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Ethnicity: Native American/Alaska Native Asian African American Hispanic/Latino Native Hawaiian/Pacific Islander White Other Decline to Answer

Responsible Party/Legal Guardian (if different than patient): _____ Relationship: _____

Contact Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Email: _____ Home/Cell: _____

Employer: _____ Work Phone: _____

Referred by: _____ Dentist Physician Patient Other

Provider Information

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ Office Phone: _____

City: _____ State: _____ Zip: _____

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip: _____

Additional Provider Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip: _____

Patient/Parent Signature: _____ Date: _____

Please answer below for: What is your chief concern and reason for this visit?

Do you currently experience any of the following symptoms?

Please number your top chief complaints 1-4

Recent is in the last 6 months, Chronic is longer than 6 months

	Recent	Chronic		Recent	Chronic
___ Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Teeth Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
___ Chewing Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Acid Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
___ Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Affect Sleep of Others	<input type="checkbox"/>	<input type="checkbox"/>
___ Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Difficulty Falling Asleep	<input type="checkbox"/>	<input type="checkbox"/>
___ Facial Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Dry Mouth Upon Waking	<input type="checkbox"/>	<input type="checkbox"/>
___ Headache (inside head)	<input type="checkbox"/>	<input type="checkbox"/>	___ Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
___ Headache (outside head)	<input type="checkbox"/>	<input type="checkbox"/>	___ Feeling Un-refreshed in the AM	<input type="checkbox"/>	<input type="checkbox"/>
___ Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Frequent Heavy Snoring	<input type="checkbox"/>	<input type="checkbox"/>
___ Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Morning Headaches	<input type="checkbox"/>	<input type="checkbox"/>
___ Nerve Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Morning Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
___ Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
___ Tooth Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Nighttime Awakenings	<input type="checkbox"/>	<input type="checkbox"/>
___ Throat Pain	<input type="checkbox"/>	<input type="checkbox"/>	___ Nighttime Choking	<input type="checkbox"/>	<input type="checkbox"/>
___ Difficulty Closing Mouth	<input type="checkbox"/>	<input type="checkbox"/>	___ Nighttime Urination	<input type="checkbox"/>	<input type="checkbox"/>
___ Difficulty Opening Mouth	<input type="checkbox"/>	<input type="checkbox"/>	___ Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
___ Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	___ Significant Daytime Drowsiness	<input type="checkbox"/>	<input type="checkbox"/>
___ Dyskinesia	<input type="checkbox"/>	<input type="checkbox"/>	___ Sore Jaw Upon Waking	<input type="checkbox"/>	<input type="checkbox"/>
___ Ear Stuffiness (congestion)	<input type="checkbox"/>	<input type="checkbox"/>	___ Swelling in Ankles or Feet	<input type="checkbox"/>	<input type="checkbox"/>
___ Ear Itching	<input type="checkbox"/>	<input type="checkbox"/>	___ Told I Stop Breathing at Sleep	<input type="checkbox"/>	<input type="checkbox"/>
___ Jaw Locking Open	<input type="checkbox"/>	<input type="checkbox"/>	___ Teeth Grinding	<input type="checkbox"/>	<input type="checkbox"/>
___ Jaw Locking Closed	<input type="checkbox"/>	<input type="checkbox"/>	___ Teeth Clenching	<input type="checkbox"/>	<input type="checkbox"/>
___ Muscle Spasm	<input type="checkbox"/>	<input type="checkbox"/>	___ Tossing and Turning Frequently	<input type="checkbox"/>	<input type="checkbox"/>
___ Noises in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	___ Unable to Tolerate C-Pap	<input type="checkbox"/>	<input type="checkbox"/>
___ Numbness (Localized)	<input type="checkbox"/>	<input type="checkbox"/>	___ Vivid Dreams	<input type="checkbox"/>	<input type="checkbox"/>
___ Ringing in Ears (Tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>	___ Jaw/Facial Fatigue upon waking	<input type="checkbox"/>	<input type="checkbox"/>
___ Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	___ Kicking or jerking of leg(s)	<input type="checkbox"/>	<input type="checkbox"/>
___ Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	___ Any other symptoms not listed: _____		
___ Changes in Bite	<input type="checkbox"/>	<input type="checkbox"/>			
___ Dental Pain	<input type="checkbox"/>	<input type="checkbox"/>			
___ Teeth Crowding or Spacing issues	<input type="checkbox"/>	<input type="checkbox"/>			

What is your level of head, neck or facial pain: 0 = no pain to 10 = worst possible pain

Currently: _____ At its best: _____ At its worst: _____

What are the results you are seeking from treatment?

Patient/Parent Signature: _____ Date: _____

Sleep Conditions - Please select the yes or no answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Position? Side Back Stomach Varies Sleep Location? Bed Couch Chair Other

Bed Partner? Yes No Average hours you sleep during the night? _____

Is it easy to fall asleep? Yes No How many hours do you sleep during the day? _____

Do you wake often during the night? Yes No Cough, gasps or snorts on waking? Yes No

Do you feel rested upon waking? Yes No Observed pauses in breath? Yes No

Stopped breathing during sleep? Yes No

Have you ever had a Sleep Study? Yes No HST PSG Date: _____ Result: _____

Previous Positive Airway Pressure Devices Used? CPAP BiPAP ASV APAP

Do you currently use a PAP Device? Yes No Type: _____

Have you previously used a Nighttime Oral Appliance? Yes No Type: _____

Allergic Reactions

Please check any and all medications or substance that have caused an allergic reaction

- | | | |
|---------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Metals | <input type="checkbox"/> Plastics |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Sulfa |
- Food Allergies/Sensitivities _____
- Other: _____

Current Medications

Please list all medications & supplements (over-the-counter & prescription) you are taking and the reason you take them **OR** Provide a copy of your personal Medication List

Medication	Dose	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

See attached list

Previous Treatment, Medications and Other Therapies Attempted For The Condition We Are Evaluating

Treatment/Medication	Doctor/Provider	Approximate Date of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

See attached

Health And Medical History

- FOR FEMALE PATIENTS: Are you currently pregnant? Yes No
- Do you drink 4 or more cups of coffee per day? Yes No
- Do you smoke tobacco? Yes No
- Do you consume alcohol or take sedatives for pain relief or sleeping aid? Yes No
- Do you have trouble breathing through your nose? Yes No
- Have you had prior orthodontic treatments? Yes No
- Have you sustained injury to: Head Neck Face Teeth
- Other: _____ Approximate Date: _____

Surgical History - Have you had any of the following:

- | | | | |
|--------------------|--|---------------------------|--|
| General Anesthesia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthognathic Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Adenoids Removed | <input type="checkbox"/> Yes <input type="checkbox"/> No | Oral Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tonsils Removed | <input type="checkbox"/> Yes <input type="checkbox"/> No | Removal of Third Molar(s) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Jaw Joint Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | (Wisdom Teeth) | |
- Other types of surgery: _____

Patient/Parent Signature: _____ Date: _____

Medical History – Patient and Family

Do you have or have experienced any of the following?

	<u>PATIENT HX</u>	<u>FAMILY HX</u>
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Awakenings from Sleep x	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Bleeding Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Birth Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Bruising Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Cancer of _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Chemo	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Chronic Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Cold Hands and Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Difficulty Concentrating	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Difficulty Breathing at Night	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
(EDS) Ehlers-Danlos Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Fluid Retention	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Frequent Colds/Flu	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Frequent Ear Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Frequent Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Gastroesophageal Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Hearing Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Heart Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Heart Valve Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
History of Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Huntington’s Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx

I HAVE NO FAMILY HX

	<u>PATIENT HX</u>	<u>FAMILY HX</u>
Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Insomnia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Intestinal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Meniere’s Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Muscle Aches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Muscle Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Muscle Spasms	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Neuralgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Nervous system Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Ovarian Cyst	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Parkinson’s Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Poor Circulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
(POTS) Postural Orthostatic Tachycardia Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Recent Weight Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Recent Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Skin Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Slow Healing Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Speech Difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Swollen or Painful Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Tired Muscles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
Urinary Tract Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Fam Hx
OTHER _____		

Patient/Parent Signature: _____ **Date:** _____

Additional Symptoms – HEAD PAIN **Please complete for all that apply:**

1. Do you experience General Head Pain? Yes No

	Location			Recent/Chronic		Severity			Duration			Frequency		
	L	R	B		(over 6mo.)	Mild	Mod	Severe	Hrs	Days	Wks	Occ.	Freq	Constant
2. Temple Area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Back of Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Forehead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Top of Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For the below categories, please indicate L or R where applicable

Jaw Pain

I have no jaw pain

Jaw pain with opening	<input type="checkbox"/> L	<input type="checkbox"/> R
Jaw pain when chewing	<input type="checkbox"/> L	<input type="checkbox"/> R
Jaw pain at rest	<input type="checkbox"/> L	<input type="checkbox"/> R

Jaw Joint Sounds

I have no jaw joint sounds

Jaw sounds with opening	<input type="checkbox"/> L	<input type="checkbox"/> R
Jaw sounds when chewing	<input type="checkbox"/> L	<input type="checkbox"/> R

Ear Related Conditions

Buzzing in ears	<input type="checkbox"/> L	<input type="checkbox"/> R
Ear Congestion	<input type="checkbox"/> L	<input type="checkbox"/> R
Ear pain	<input type="checkbox"/> L	<input type="checkbox"/> R
Hearing Loss	<input type="checkbox"/> L	<input type="checkbox"/> R
Itchiness/stuffiness	<input type="checkbox"/> L	<input type="checkbox"/> R

Pain behind the ear	<input type="checkbox"/> L	<input type="checkbox"/> R
Pain in front of ear	<input type="checkbox"/> L	<input type="checkbox"/> R
Recurrent ear infections	<input type="checkbox"/> L	<input type="checkbox"/> R
ringing in the ear (tinnitus)	<input type="checkbox"/> L	<input type="checkbox"/> R

For the below categories, please respond with Yes or No DO NOT LEAVE BLANK

Jaw Locking

Jaw locks closed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jaw locks open	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Jaw Joint Symptoms

Teeth clenching	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Day	<input type="checkbox"/> Night
Teeth grinding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Day	<input type="checkbox"/> Night

Eye Related Conditions

Blurred vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Double vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Pain or pressure behind the eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Extreme sensitivity to light	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wear of glasses or contacts	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Throat Related Conditions

Chronic sore throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty Swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swollen glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Thyroid enlargement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tightness in throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Feeling of foreign object in throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Neck related Conditions

Limited movement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neck pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Numbness in hands/fingers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling in neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Shoulder Conditions

Pain in Shoulders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stiffness in Shoulders	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Tingling in fingers/hands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Back Conditions

Low Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Middle Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Upper Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Scoliosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sciatica	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Mouth/Nose Conditions

Chronic Sinusitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dry Mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Broken Teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Biting Cheeks	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Burning Tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patient/Parent Signature: _____ Date: _____

History of Symptoms

On what date, or approximate date, did the condition you are seeking treatment for occur? _____

Are any of the conditions listed or was your chief complaint caused by a motor vehicle accident? Yes No

If yes, what conditions: _____ Date of accident: _____

Does any family member have a sleep breathing disorder? Yes No If yes, explain: _____

Please fully complete both sections 1. and 2. below

1. DAYTIME SLEEPINESS EVALUATION - EPWORTH SLEEPINESS SCALE

For the following situations, answer with one of the following numbers:

0 - would never doze 1 - slight chance of dozing 2 - moderate chance of dozing 3 - high chance of dozing

Situation	Score	Situation	Score
Sitting and reading	_____	Sitting and talking to someone	_____
Watching Television	_____	Sitting quietly after a lunch (no alcohol)	_____
Sitting, inactive public place	_____	In a car, while stopped for a few minutes in traffic	_____
As a passenger in a car for an hour without a break	_____	Lying down to rest in the afternoon when circumstances permit	_____
TOTAL SCORE			_____

2. NIGHTTIME SLEEPINESS EVALUATION

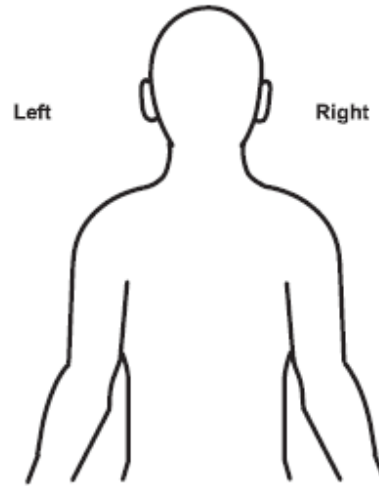
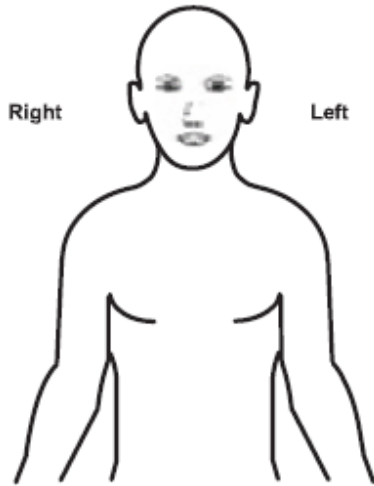
Developed by David White, M.D., Harvard Medical School, Boston, MA

1. Snoring		Score	
a) Do you snore on most nights (>3 nights per week)?			
Yes (2)	No (0)	_____	
b) Is your snoring loud? Can it be heard through a door or wall?			
Yes (2)	No (0)	_____	
2. Has it ever been reported to you that you stop breathing or gasp during sleep?			
Never (0)	Occasionally (3)	Frequently (5)	

3. What is your collar size?			
Male: Less than 17 inches (0)	More than 17 inches (5)		
Female: Less than 16 inches (0)	More than 16 inches (5)	_____	
4. Do you occasionally fall asleep during the day when:			
a) You are busy or active			
Yes (2)	No (0)	_____	
b) You are driving or stopped at a light?			
Yes (2)	No (0)	_____	
5. Have you had or are you being treated for high blood pressure?			
Yes (2)	No (0)	_____	
TOTAL			_____

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, third party billing companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance covers.

Patient/Parent Signature: _____ Date: _____



Indicate Areas of Pain
Following the Pain Scale:
1 Mild pain
2 Moderate pain
3 Severe pain