PATIENT INFORMATION

DENTIST: _____

PHYSICIAN: _____

WELCOME TO OUR OFFICE!

Date _____

Patient's Name: _____ (Last Name) _____ (First Name) _____ (M. I.)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Birth Date _____ Social Security # _____

If patient is minor, give parent or guardian's name _____

Patient Email Address _____ Responsibly Party E-mail address _____

RESPONSIBLE PARTY INFORMATION

Name: _____ (Last Name) _____ (First Name) _____ (M. I.) _____ (Marital Status)

Residence: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Phone _____ Work Phone _____

Previous address (if less than 3 years): _____ (Street) _____ (City) _____ (State) _____ (Zip)

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. of Years Employed _____

Spouse's Name: _____ (Last Name) _____ (First Name) _____ (M.I.) _____ (Relationship to Patient)

Employer _____ Occupation _____ No. of Years Employed _____

Spouse's Name: _____ (Last Name) _____ (First Name) _____ (M.I.) _____ (Relationship to Patient)

INSURANCE INFORMATION

Insured's Name _____ Date of Birth _____ Insured's Soc. Sec # _____

Insured's Company _____ Group # _____ Local # _____

Insurance Company Address _____

Do you have Dual Coverage? Yes ☐ No ☐ If yes, please continue: _____

Secondary Insured's Name _____ Date of Birth _____ Insured's Soc. Sec # _____

Insured's Company _____ Group # _____ Local # _____

Insurance Company Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not Living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____ Date _____

I understand that where appropriate, credit bureau reports may be obtained.

MEDICAL HEALTH HISTORY

PLEASE CHECK ANY OF TH FOLLOWING FOR WHICH THE PATIENT HAS BEEN DIAGNOSED OR TREATED: PLEASE COMMENT IF NECESSARY.

☐ ADENOIDS ☐ ANEMIA ☐ ARTHRITIS ☐ ASTHMA ☐ POLIO
☐ EMOTIONAL PROBLEMS ☐ EPILEPSY ☐ BONE DISORDERS
☐ DIABETES ☐ ENDOCRINE ☐ PNEUMONIA ☐ POOR HEALTH
☐ PROLONGED BLEEDING ☐ RHEUMATIC ☐ TUBERCULOSIS
☐ FAINTING, DIZZINESS ☐ FEVER HEPATITIS ☐ NONE OF THESE

WEIGHT _____ HEIGHT _____

DOES PATIENT HAVE TENDENCY TO COLDS? YES ☐ NO ☐
SORE THROATS? YES ☐ NO ☐ EAR INFECTIONS? YES ☐ NO ☐

HAVE TONSILS OR ADENOIDS BEEN REMOVED? YES ☐ NO ☐ WHAT AGE? _____
BROKEN BONES? PLEASE LIST. DID THEY HEAL SATISFACTORILY?
_____
DOES PATIENT BLEED EASILY? YES ☐ NO ☐
HAVE HIGH FEVER WITH CHILDHOOD DISEASES? YES ☐ NO ☐
ANY PSYCHOLOGICAL COUNSELING? _____
_____
OTHER ILLNESSES, CONDITIONS, ALLERGIES, ETC.: _____
_____
DID PATIENT EVER HAVE AN ALLERGY TO ANY DRUG OR MEDICATION: YES ☐ NO ☐
YES, REMARKS _____
TO THE BEST OF YOUR KNOWLEDGE, IS THE PATIENT IN GOOD HEALTH? YES ☐ NO ☐

IF PATIENT IS UNDER THE CARE OF A PHYSICIAN FOR A SPECIFIC CONDITION OR IS TAKING ANY MEDICATIONS, PLEASE EXPLAIN AND LIST.

_____
_____
_____
_____
_____
_____

DENTAL HEALTH HISTORY

HAS THE PATIENT HAD ANY INJURIES TO THE FACE?
☐ MOUTH ☐ TEETH ☐ FACE

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? YES ☐ NO ☐
UNTIL WHAT AGE? _____
DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? YES ☐ NO ☐
IS THE PATIENT A MOUTH-BREATHER?

WHILE AWAKE? _____ WHILE ASLEEP? HAS _____

THE PATIENT HAD ANY TEETH REMOVED AT ANY TIME BY A DENTIST? YES ☐ NO ☐
WHICH TEETH? _____
DOES THE PATIENT (GRIND) THE TEETH OR (BITE) HIS OR HER LIP? YES ☐ NO ☐
PLEASE UNDERLINE _____

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? YES ☐ NO ☐
DOES FACE AND MOUTH RESEMBLE: ☐ MOTHER ☐ FATHER ☐ NEITHER

DO YOU MAKE REGULAR VISITS TO THE DENTIST? YES ☐ NO ☐
WHEN LAST? _____

HOW OFTEN DOES PATIENT BRUSH HIS/HER TEETH? _____

ANY PAIN IN OR NEAR THE EARS? YES ☐ NO ☐
☐ RIGHT LEFT ☐

ANY CLICKING OR DISCOMFORT OF THE JAW JOINT NEAR EARS? YES ☐ NO ☐
☐ RIGHT LEFT ☐

DOES PATIENT DESIRE TREATMENT? YES ☐ NO ☐

IN YOUR OWN WORDS WHAT WOULD YOU LIKE US TO ACCOMPLISH FOR YOU?
_____
_____

OTHER RELEVANT INFORMATION: _____
_____
_____
_____
_____
_____

_____ _____
SIGNATURE DATE

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HEAD HEALTH HISTORY

PATIENT INFORMATION

NAME | DATE | AGE | SEX | TELEPHONE

TODAY / /

DENTAL FOUNDATION (TEETH, MUSCLES, JOINTS)

#			
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
2	Where do you think your teeth hit or fit first? ☐ More on the right ☐ Left ☐ Equal ☐ More on the front ☐ Back ☐ Equal		
3	Do your jaw muscles get tight or sore? » When? ☐ Morning ☐ Evening ☐ After chewing	☐ Yes	☐ No
4	Do you have pain or difficulty opening wide?	☐ Yes	☐ No
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

CAUSES & COMPLICATIONS

#			
6	Do you grind or clench your teeth? » Do you wear a: ☐ Splint ☐ Night Guard ☐ Retainer	☐ Yes	☐ No
7	Have you had any significant dental treatments? ☐ Orthodontics ☐ Oral Surgery / wisdom teeth removal ☐ Long dental appointments ☐ Other	☐ Yes	☐ No
8	Have you been in a car accident, major or minor? » How many? _____ » When was the last accident? ☐ 0-6 Months ☐ 6-12 Months ☐ More than 1 year » Did you see the accident coming? ☐ Yes ☐ No » Did the airbag deploy? ☐ Yes ☐ No	☐ Yes	☐ No
9	Have you had sports injuries and / or trauma to your head & neck? » When? ☐ Less than 1 year ☐ More than 1 year	☐ Yes	☐ No
10	Do you work at a desk, computer or in forward head posture position? Do you have any other postural position problems? _____	☐ Yes	☐ No
11	Daytime sleepiness, drowsiness, or tiredness?	☐ Yes	☐ No
12	Problem with sleep? » Insomnia ☐ Yes ☐ No » Sleep Apnea ☐ Yes ☐ No » Sleep Disturbances ☐ Yes ☐ No » Less than 7 hours per night ☐ Yes ☐ No » Other _____		

SYMPTOMS

#			
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		
14	Do you esperience ringing or fullness in your ears? ☐ Yes ☐ No » Which one? ☐ Right ☐ Left ☐ Both		
15	How oftern 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		
16	How often do you get other milder headaches? ☐ Daily ☐ More than 3 per week ☐ More than 2 per month ☐ Other _____		
17	Have your headaches changed in the last six months? ☐ About the same ☐ Slightly worsening ☐ Same but more frequent ☐ A lot worse Got worse when _____		

IMPACT ON DAILY LIVING ACTIVITIES

#			
18	What is your stress level? ☐ Mild ☐ Moderate ☐ Severe		
19	Do you have anxiety? ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe		
20	Because of pain, headaches or migraines, in the last month: # Of days you could not go to school _____ # Of days did reduced amount of work _____ # Of days you could not do usual household work/parenting _____ # Of days you missed family or social functions _____		
21	When you havae pain, headaches or migraines, how does that make you feel? *(Check all that apply)* ☐ Angry ☐ Depressed ☐ Tired or exhausted ☐ Fustrated ☐ Guilty ☐ Ashamed ☐ Relationship tension ☐ Other		
22	How many days per month are you: Pain Free? _____ Headache Free? _____		

NOTES: _____

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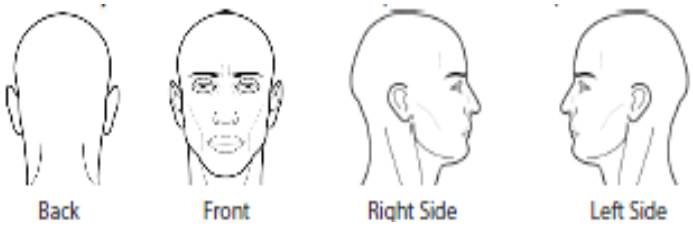
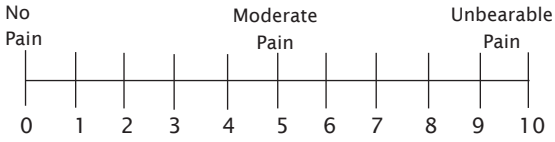
HEADACHE HISTORY

PATIENT INFORMATION

NAME | DATE | AGE | SEX | TELEPHONE

TODAY / / _____ _____ _____

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

#	QUESTIONS
1	Have you been diagnose with **any** of the following? » ☐ Migrane » ☐ Chronic Daily Headache » ☐ Tension Headache » ☐ Cluster Headache » ☐ Medication Overuse Headache » ☐ Menstrual Migrane » ☐ None » ☐ Other _____
2	What sets off or triggers your headaches? _____
3	What test have you had to help diagnose your headaches? » ☐ MRI » ☐ CT Scan » ☐ Blood Tests » ☐ Hormone Testing
4	Where are your headaches located? (Mark Locations)  Back Front Right Side Left Side On a sacle of 1-10, how painful are your headaches/migraines?  No Pain — Moderate Pain — Unbearable Pain 0 1 2 3 4 5 6 7 8 9 10
5	Describe the type of headache pain you feel most often: » ☐ Achy » ☐ Throbbing » ☐ Stabbing » ☐ Other _____
6	What other doctors have you seen for your pain, headaches, and/or migraines? ☐ GP/FAMILY DOCTOR/OB-GYN _____ ☐ DENTIST (IF EITHER) _____ ☐ NEUROLOGIST _____ ☐ PSYCHIATRIST/PSYCHOLOGIST _____ ☐ PHYSICAL THERAPIST _____ ☐ CHIROPRACTER _____ ☐ EAR NOSE THROAT _____ ☐ OTHER _____
7	What medications do you use for headache, migraine, or pain relief?

MEDICATION (NAME OF MEDICATION OR SUBSTANACE)	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 ( )		
Caffein intake ( )		
Alcohol intake ( )		
THC, Medical Marijuana ( )		
Other: ( )		

#	QUESTIONS
8	Do you try non-medicating techniques for managing your pain or headaches? ☐ Yes ☐ No » ☐ Yoga » ☐ Breathing Exercises » ☐ Cold Packs » ☐ Massage » ☐ Meditation » ☐ Physical Therapy » ☐ Hot Packs/Hot Bath » ☐ Acupuncture » ☐ Exercise » ☐ Other (please describe) _____

I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION BEST DESCRIBES THE TREATMENTS AND MEDICATIONS I HAVE USED TO HELP ALLEVIATE MY HEADACHES/MIGRAINES/PAIN.

PATIENT SIGNATURE _____