

PATIENT INFORMATION

NAME	DATE	TELEPHONE
Please, list the names of any healthcare professionals you or your family see:		
<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"/> MASSAGE THERAPIST <input type="checkbox"/> OTHER	_____ _____ _____ _____

Please review and answer any part that applies for each question.

#	GENERAL QUESTIONS
1	Were you referred by someone? <input type="checkbox"/> Yes <input type="checkbox"/> No » If Yes, who referred you to our office? _____ » What is their relationship to you? _____
2	Are you presently under the care of a doctor or taking any prescriptions? <input type="checkbox"/> Yes <input type="checkbox"/> No » If Yes, physician's name(s): _____ » What condition(s) are you being treated for? _____ _____ » What treatment / medication(s) are you taking? _____ _____
3	Do you have any problems with your jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Clicking <input type="checkbox"/> Popping <input type="checkbox"/> Grinding <input type="checkbox"/> Jaw Injury <input type="checkbox"/> Jaw Locks Open <input type="checkbox"/> Jaw Locks Closed or Partially Closed » If injury, when and how did this injury occur? _____ _____ » If not injury, how long have you had these problem(s): _____ » How you previously received treatment for this problem(s): <input type="checkbox"/> Yes <input type="checkbox"/> No » If yes, who directed this treatment? _____ Mark the type of treatment(s) below and provide details: <input type="checkbox"/> Bite Splint - Result: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Medication - Result: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Physical Therapy - Result: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Occlusal Adjustment - Result: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Orthodontics - Results: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Surgery - Results: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Other _____ - Results: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
4	Do you have pain in any of the following areas? <input type="checkbox"/> Jaw Joints <input type="checkbox"/> Jaw Muscles <input type="checkbox"/> Muscles Under the Side of Jaws <input type="checkbox"/> Ears <input type="checkbox"/> Temples (Side of Head) <input type="checkbox"/> In or Behind the Eyes <input type="checkbox"/> Back of Neck <input type="checkbox"/> Side of Neck
5	Do you consider yourself to be under more stress than most people? <input type="checkbox"/> Yes <input type="checkbox"/> No

#	HEADACHE HISTORY AND DETAILS
1	Where are your headaches located? <input type="checkbox"/> Temples (sides of head) <input type="checkbox"/> Occipital (back of head) <input type="checkbox"/> Frontal (front of head) <input type="checkbox"/> Top of head
2	How severe are your headaches? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
3	Describe the type of headache pain you feel most often: <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Stabbing <input type="checkbox"/> Other _____
4	Duration of headaches: » How long do your headaches normally last? _____ hours _____ days » How long would they last, if you did nothing to abate them? _____
5	Do you take medications for headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No » What medication(s) are you taking? _____ _____ » Dosage: Describe how much and how often? _____ _____ » After medicating, how long does it take for the headache to go away? _____
6	Do you try non-medicating techniques for managing your headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yoga <input type="checkbox"/> Breathing Exercises <input type="checkbox"/> Cold Packs <input type="checkbox"/> Massage <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Other (please describe) _____ _____
7	Have you been diagnosed with Migraines? <input type="checkbox"/> Yes <input type="checkbox"/> No » How long ago were you diagnosed? _____ » What did the doctor recommend for treatment? _____ _____ _____ _____ » Did the treatment help? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____ _____ _____ _____	

When finished, please return to our office staff.