

DATE OF EXAMINATION:

THIS QUESTIONNAIRE IS DESIGNED TO PROVIDE IMPORTANT FACTS REGARDING THE HISTORY OF YOUR PRESENT CONDITION. THE INFORMATION YOU PROVIDE WILL ASSIST IN REACHING A DIAGNOSIS AND DETERMINING THE SOURCE OF YOUR PROBLEM. PLEASE TAKE YOUR TIME ANSWERING EACH QUESTION AS COMPLETELY AND HONESTLY AS POSSIBLE.

1. PLEASE INDICATE ANY OF THE FOLLOWING YOU ARE NOW EXPERIENCING OR HAVE EXPERIENCED IN THE PAST:

HEAD/FACE

- Forehead headaches
- Temporal headaches
- Tension headaches
- Migraine-type headaches
- Sinus headaches
- Back of head headaches
- Scalp tender to touch

EARS

- Ear pain without infection
- Decreased hearing
- Clogged/stuffy feeling in ear(s)
- Itchy feeling in ear(s)
- Ringing/buzzing in ear(s)
- Dizziness
- Balance problems

THROAT

- Difficulty swallowing
- Feeling of foreign object in throat
- Sore throat without infection
- Voice changes
- Laryngitis
- Frequent coughing or clearing

NECK

- Lack of mobility
- Stiffness
- Neck pain
- Tired/sore neck muscles
- Shoulder pain
- Back pain
- Arm/finger pain or numbness

EYES

- Pain in/around eyes
- Bloodshot eyes
- Sensitivity to light
- Tearing of eyes
- Blurred vision
- Pressure behind eyes
- Dark circles under eyes

NASAL

- Sinus pain
- Sinus problems
- Post-nasal drainage
- Allergies

JAW

- Jaw pain
- Jaw joint pain
- Clicking/popping in jaw joint(s)
- Grinding sound in jaw joint(s)
- Pain in cheek muscles
- Uncontrollable jaw movements
- Jaw locks open/shut
- Deviation of jaw to one side

MOUTH

- Abnormal opening
- Limited opening
- Bad bite
- Missing teeth
- Clenching/grinding teeth
- Mouth discomfort
- Inability to find bite
- Burning tongue
- Sour or foul taste in mouth

SLEEP

- Snoring
- Sleep apnea
- Have been told I snore
- Have been told I stop breathing
- Have awoken gasping for air

2. WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING CARE? PLEASE ORDER COMPLAINTS BY NUMBER (1=MOST IMPORTANT, 10=LEAST)

<input type="checkbox"/> THROAT PAIN	<input type="checkbox"/> BACK PAIN	<input type="checkbox"/> PAIN BEHIND EYES	<input type="checkbox"/> VISUAL DISTURBANCES
<input type="checkbox"/> JAW CLICKING	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> PAIN WHEN CHEWING	<input type="checkbox"/> SINUS CONGESTION
<input type="checkbox"/> JAW JOINT NOISE	<input type="checkbox"/> EAR PAIN	<input type="checkbox"/> RINGING IN EARS	<input type="checkbox"/> MUSCLE TWITCHING
<input type="checkbox"/> JAW LOCKING	<input type="checkbox"/> FACIAL PAIN	<input type="checkbox"/> SHOULDER PAIN	<input type="checkbox"/> INABILITY TO OPEN MOUTH
<input type="checkbox"/> JAW PAIN	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> LIMITED MOUTH OPENING	<input type="checkbox"/> OTHER: <input type="text"/>
<input type="checkbox"/> NECK PAIN	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> EAR CONGESTION	<input type="checkbox"/> OTHER: <input type="text"/>

3. PLEASE LIST TREATMENTS YOU HAVE RECEIVED, AS WELL AS HEALTH CARE PROFESSIONALS YOU HAVE SEEN.

	PRACTICIONER	SPECIALTY	TREATMENT RECEIVED	APRX DATE
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

4. THE EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale (ESS) was developed and validated by Dr. Murray Johns of Melbourne, Australia. It is a simple, self-administered questionnaire that is widely used by sleep professionals in quantifying the level of daytime sleepiness.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 'just tired'? This refers to your usual way of life at present and in the recent past. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

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

SITUATION

- Sitting and reading
- Watching television
- Sitting, inactive in a public place (e.g. theatre, meeting)
- As a passenger in a car for an hour without a break
- Lying down to rest in the afternoon when circumstances permit
- Sitting and talking to someone
- Sitting quietly after lunch without alcohol
- In a car, while stopped for a few minutes in traffic

CHANCE OF DOZING

TOTAL SCORE _____

5. PLEASE INDICATE ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION

NO ALLERGIES

- ANTIBIOTICS
- ASPIRIN
- BARBITURATES
- CODEINE
- IODINE

- LATEX
- LOCAL ANESTHETIC
- METALS
- PENICILLIN
- PLASTICS

- SEDATIVES
- SLEEPING PILLS
- SULFA DRUGS

OTHER _____

OTHER _____

6. PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN

NO MEDICATIONS

- ANTIBIOTICS
- ANTICOAGULANTS
- BARBITURATES
- BLOOD THINNERS
- CODEINE

- CORTISONE
- DIET PILLS
- HEART MEDICATION
- INSULIN
- MUSCLE RELAXANTS

- NERVE PILLS
- PAIN MEDICATION
- SLEEPING PILLS
- SULFA DRUGS
- TRANQUILIZERS

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

7. PLEASE COMPLETE THE FOLLOWING MEDICAL/DENTAL HISTORY

DETAILS

<input type="checkbox"/> ADENOIDS REMOVED?	
<input type="checkbox"/> TONSILS REMOVED?	
<input type="checkbox"/> ANEMIA	
<input type="checkbox"/> ARTERIOSCLEROSIS	
<input type="checkbox"/> ASTHMA	
<input type="checkbox"/> AUTOIMMUNE DISORDER	
<input type="checkbox"/> BLEEDING EASILY	
<input type="checkbox"/> HIGH BLOOD PRESSURE	
<input type="checkbox"/> LOW BLOOD PRESSURE	
<input type="checkbox"/> BRUISING EASILY	
<input type="checkbox"/> CANCER	
<input type="checkbox"/> CHEMOTHERAPY	
<input type="checkbox"/> CHRONIC FATIGUE	
<input type="checkbox"/> COLD HANDS/FEET	
<input type="checkbox"/> CURRENT PREGNANCY	
<input type="checkbox"/> DEPRESSION	
<input type="checkbox"/> DIABETES	
<input type="checkbox"/> DIFFICULTY FOCUSING	
<input type="checkbox"/> DIZZINESS	
<input type="checkbox"/> EMPHYSEMA	
<input type="checkbox"/> EPILEPSY	
<input type="checkbox"/> EXCESSIVE THIRST	
<input type="checkbox"/> FLUID RETENTION	
<input type="checkbox"/> FREQUENT COUGH	
<input type="checkbox"/> FREQUENT ILLNESS	
<input type="checkbox"/> FREQUENT STRESS	
<input type="checkbox"/> GENERAL ANESTHESIA	
<input type="checkbox"/> GLAUCOMA	
<input type="checkbox"/> GOUT	
<input type="checkbox"/> HAY FEVER	
<input type="checkbox"/> HEARING IMPAIRMENT	
<input type="checkbox"/> HEART MURMUR	
<input type="checkbox"/> HEART DISORDER	
<input type="checkbox"/> HEART PACEMAKER	
<input type="checkbox"/> HEART PALPITATIONS	
<input type="checkbox"/> HEART VALVE REPL.	
<input type="checkbox"/> HEMOPHILIA	
<input type="checkbox"/> HEPATITIS	
<input type="checkbox"/> HYPOGLYCEMIA	
<input type="checkbox"/> IMMUNE DISORDER	
<input type="checkbox"/> INJURY TO FACE	
<input type="checkbox"/> INJURY TO NECK	
<input type="checkbox"/> INJURY TO MOUTH	
<input type="checkbox"/> INJURY TO TEETH	
<input type="checkbox"/> INSOMNIA	
<input type="checkbox"/> INTESTINAL DISORDER	

<input type="checkbox"/> JAW JOINT SURGERY	
<input type="checkbox"/> KIDNEY PROBLEMS	
<input type="checkbox"/> LIVER DISEASE	
<input type="checkbox"/> MENIERE'S DISEASE	
<input type="checkbox"/> MENSTRUAL CRAMPS	
<input type="checkbox"/> MULTIPLE SCLEROSIS	
<input type="checkbox"/> MUSCLE ACHES	
<input type="checkbox"/> MUSCLE TREMORS	
<input type="checkbox"/> MUSCLE CRAMPS	
<input type="checkbox"/> MUSCULAR DYSTROPHY	
<input type="checkbox"/> NEED PILLOW AT NIGHT	
<input type="checkbox"/> NERVOUS IRRITABILITY	
<input type="checkbox"/> NERVOUSNESS	
<input type="checkbox"/> NEURALGIA	
<input type="checkbox"/> OSTEOPOROSIS	
<input type="checkbox"/> PARKINSON'S DISEASE	
<input type="checkbox"/> POOR CIRCULATION	
<input type="checkbox"/> PRIOR ORTHODONTICS	
<input type="checkbox"/> PSYCHIATRIC CARE	
<input type="checkbox"/> RADIATION TREATMENT	
<input type="checkbox"/> RHEUMATIC FEVER	
<input type="checkbox"/> RHEUMATOID ARTHRITIS	
<input type="checkbox"/> SCARLET FEVER	
<input type="checkbox"/> SHORTNESS OF BREATH	
<input type="checkbox"/> SINUS PROBLEMS	
<input type="checkbox"/> SKIN DISORDERS	
<input type="checkbox"/> SLOW HEALING SORES	
<input type="checkbox"/> SPEECH DIFFICULTY	
<input type="checkbox"/> STROKE	
<input type="checkbox"/> SWOLLEN JOINTS	
<input type="checkbox"/> FREQUENT COLDS	
<input type="checkbox"/> FREQ SORE THROAT	
<input type="checkbox"/> FREQ EAR INFECTION	
<input type="checkbox"/> TUBERCULOSIS	
<input type="checkbox"/> TUBES IN EARS	
<input type="checkbox"/> TUMORS	
<input type="checkbox"/> URINARY DISORDERS	
<input type="checkbox"/> 3RD MOLAR EXTRACTION	

8. PLEASE PROVIDE INFORMATION REGARDING YOUR CURRENT CONDITION

WHEN DID YOUR CONDITION FIRST OCCUR?

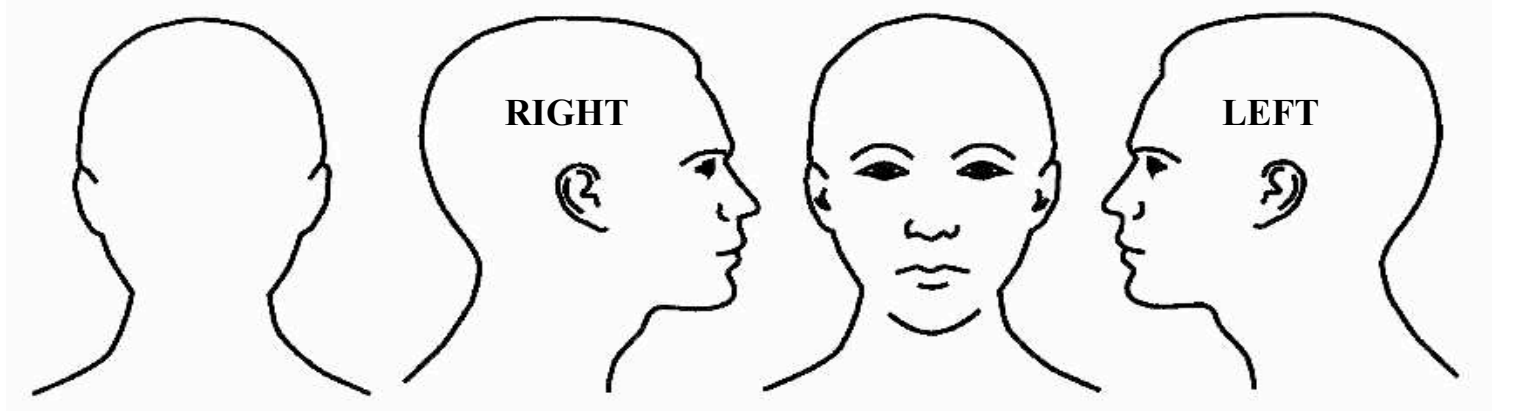
WHAT DO YOU BELIEVE TO BE THE CAUSE OF YOUR PAIN OR CONDITION?

<input type="checkbox"/> Motor vehicle accident	<input type="checkbox"/> Motorcycle accident	<input type="checkbox"/> Work related	<input type="checkbox"/> Fall	<input type="checkbox"/> Other
<input type="checkbox"/> Playground accident	<input type="checkbox"/> Athletic endeavor	<input type="checkbox"/> Fight	<input type="checkbox"/> Injury	
<input type="checkbox"/> Accident	<input type="checkbox"/> Heredity	<input type="checkbox"/> Illness	<input type="checkbox"/> Unknown	

OTHER IMPORTANT INFO

WHO MAY WE THANK FOR YOUR REFERRAL?

9. WHERE IS YOUR PAIN (MARK WITH AN "X")?



LOCATION		SEVERITY			FREQUENCY			DURATION			
L=LEFT R=RIGHT B=BOTH SIDES		MILD	MOD	SEV	OCC	FREQ	CONS	MIN	HRS	DAYS	WKS
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	FRONT OF HEAD	<input type="radio"/> MILD	<input type="radio"/> MOD	<input type="radio"/> SEV	<input type="radio"/> OCC	<input type="radio"/> FREQ	<input type="radio"/> CONS	<input type="radio"/> MINS	<input type="radio"/> HRS	<input type="radio"/> DAYS	<input type="radio"/> WKS
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	ENTIRE HEAD	<input type="radio"/> MILD	<input type="radio"/> MOD	<input type="radio"/> SEV	<input type="radio"/> OCC	<input type="radio"/> FREQ	<input type="radio"/> CONS	<input type="radio"/> MINS	<input type="radio"/> HRS	<input type="radio"/> DAYS	<input type="radio"/> WKS
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	TOP OF HEAD	<input type="radio"/> MILD	<input type="radio"/> MOD	<input type="radio"/> SEV	<input type="radio"/> OCC	<input type="radio"/> FREQ	<input type="radio"/> CONS	<input type="radio"/> MINS	<input type="radio"/> HRS	<input type="radio"/> DAYS	<input type="radio"/> WKS
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BACK OF HEAD	<input type="radio"/> MILD	<input type="radio"/> MOD	<input type="radio"/> SEV	<input type="radio"/> OCC	<input type="radio"/> FREQ	<input type="radio"/> CONS	<input type="radio"/> MINS	<input type="radio"/> HRS	<input type="radio"/> DAYS	<input type="radio"/> WKS
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	TEMPLE AREA	<input type="radio"/> MILD	<input type="radio"/> MOD	<input type="radio"/> SEV	<input type="radio"/> OCC	<input type="radio"/> FREQ	<input type="radio"/> CONS	<input type="radio"/> MINS	<input type="radio"/> HRS	<input type="radio"/> DAYS	<input type="radio"/> WKS
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	EAR AREA	<input type="radio"/> MILD	<input type="radio"/> MOD	<input type="radio"/> SEV	<input type="radio"/> OCC	<input type="radio"/> FREQ	<input type="radio"/> CONS	<input type="radio"/> MINS	<input type="radio"/> HRS	<input type="radio"/> DAYS	<input type="radio"/> WKS
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BACK OF NECK	<input type="radio"/> MILD	<input type="radio"/> MOD	<input type="radio"/> SEV	<input type="radio"/> OCC	<input type="radio"/> FREQ	<input type="radio"/> CONS	<input type="radio"/> MINS	<input type="radio"/> HRS	<input type="radio"/> DAYS	<input type="radio"/> WKS
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	FRONT OF NECK	<input type="radio"/> MILD	<input type="radio"/> MOD	<input type="radio"/> SEV	<input type="radio"/> OCC	<input type="radio"/> FREQ	<input type="radio"/> CONS	<input type="radio"/> MINS	<input type="radio"/> HRS	<input type="radio"/> DAYS	<input type="radio"/> WKS
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	CHEEK MUSCLES	<input type="radio"/> MILD	<input type="radio"/> MOD	<input type="radio"/> SEV	<input type="radio"/> OCC	<input type="radio"/> FREQ	<input type="radio"/> CONS	<input type="radio"/> MINS	<input type="radio"/> HRS	<input type="radio"/> DAYS	<input type="radio"/> WKS
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	SINUSES	<input type="radio"/> MILD	<input type="radio"/> MOD	<input type="radio"/> SEV	<input type="radio"/> OCC	<input type="radio"/> FREQ	<input type="radio"/> CONS	<input type="radio"/> MINS	<input type="radio"/> HRS	<input type="radio"/> DAYS	<input type="radio"/> WKS

10. PLEASE INDICATE ANY JAW PROBLEMS YOU ARE EXPERIENCING

L=LEFT R=RIGHT B=BOTH SIDES		DETAILS
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	JAW PAIN - OPENING	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	JAW PAIN - CHEWING	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	JAW PAIN - AT REST	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	JAW CLICKS	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	JAW LOCKS OPEN	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	JAW LOCKS CLOSED	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	JAW POPPING	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> Yes <input type="radio"/> No	TEETH CLENCHING	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> Yes <input type="radio"/> No	TEETH GRINDING	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	GRINDING SOUND	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> Yes <input type="radio"/> No	CURRENTLY UNDER UNUSUAL STRESS	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> Yes <input type="radio"/> No	RECENT CHANGE IN LIFESTYLE	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> Yes <input type="radio"/> No	RECENT CHANGE IN WORK PATTERN	<div style="border: 1px solid black; height: 20px;"></div>
<input type="radio"/> Yes <input type="radio"/> No	DO YOU DRINK FOUR OR MORE CAFFEINATED DRINKS A DAY?	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>
<input type="radio"/> Yes <input type="radio"/> No	DO YOU USE TOBACCO?	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>

Yes No DOES ANY FAMILY MEMBER HAVE A SIMILAR PROBLEM

DOES ANYTHING MAKE THE PAIN SUBSIDE? Medication Massage Sleep Dark Nothing Quiet

11. PLEASE INDICATE ANY EYE, EAR, MOUTH, AND/OR NOSE PROBLEMS

L=LEFT R=RIGHT B=BOTH SIDES

DETAILS

<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BLURRED VISION	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	DOUBLE VISION	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	EYE PAIN	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	PAIN BEHIND EYES	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	PRESSURE BEHIND EYES	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	SENSITIVITY TO LIGHT	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	TEARING EYES	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BLOODSHOT EYES	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BUZZING IN EARS	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	RINGING IN EARS	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	PAIN IN FRONT OF EARS	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	PAIN BEHIND EARS	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	PAIN IN EARS	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	HEARING LOSS	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	EAR INFECTIONS	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BURNING TONGUE	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BROKEN TEETH	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	CHRONIC SINUSITIS	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	DRY MOUTH	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	CHEEK BITING	<input type="text"/>
<input type="radio"/> Yes <input type="radio"/> No	SNORING/SLEEP APNEA	<input type="text"/>

12. PLEASE INDICATE ANY THROAT, NECK, AND/OR BACK SYMPTOMS

L=LEFT R=RIGHT B=BOTH SIDES

DETAILS

<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BACK PAIN - LOWER	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BACK PAIN - MIDDLE	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	BACK PAIN - UPPER	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	CHRONIC SORE THROAT	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	FEELING OF FOREIGN OBJECT IN THROAT	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	DIFFICULTY SWALLOWING	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	LIMITED NECK MOVEMENT	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	NECK PAIN	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	NUMBNESS IN HANDS	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	SCIATICA	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	SCOLIOSIS	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	SHOULDER PAIN	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	SHOULDER STIFFNESS	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	SWELLING IN NECK	<input type="text"/>
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	SWOLLEN GLANDS	<input type="text"/>

<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	THYROID ENLARGEMENT	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	TIGHTNESS IN THROAT	
<input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	TINGLING IN HANDS	

13. PLEASE INDICATE ANY ACCIDENT(S) AND/OR TRAUMATIC INCIDENT(S)

HAVE YOU EVER:

DETAILS

1. HAD A SEVERE BLOW TO THE HEAD OR JAWS? Yes No

2. HAD ANY WHIPLASH NECK INJURIES? Yes No

3. BEEN IN ANY ACCIDENT? Yes No

4. MISCELLANEOUS NOTES

I CERTIFY THAT THE ABOVE HISTORY IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNED NAME: X _____

PRINTED NAME: _____