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.

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

NECK

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

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

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

EYES

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

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

THROAT

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

NASAL

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

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)*

☐ THROAT PAIN	☐ BACK PAIN	☐ PAIN BEHIND EYES	☐ VISUAL DISTURBANCES
☐ JAW CLICKING	☐ DIZZINESS	☐ PAIN WHEN CHEWING	☐ SINUS CONGESTION
☐ JAW JOINT NOISE	☐ EAR PAIN	☐ RINGING IN EARS	☐ MUSCLE TWITCHING
☐ JAW LOCKING	☐ FACIAL PAIN	☐ SHOULDER PAIN	☐ INABILITY TO OPEN MOUTH
☐ JAW PAIN	☐ HEADACHES	☐ LIMITED MOUTH OPENING	☐ OTHER:
☐ NECK PAIN	☐ FATIGUE	☐ EAR CONGESTION	☐ OTHER:

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

	PRACTICIONER	SPECIALTY	TREATMENT RECEIVED	APRX DATE
1.				
2.				
3.				
4.				
5.				
6.				

HAVE YOU TAKEN FOSAMAX, BONIVA, OR ANY OTHER BISPHOSPHONATE DRUG IN THE PAST ☐ **Yes** ☐ **No**

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	CHANCE OF DOZING
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	_____

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

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

8. *PLEASE PROVIDE INFORMATION REGARDING YOUR CURRENT CONDITION*

WHEN DID YOUR CONDITION FIRST OCCUR?

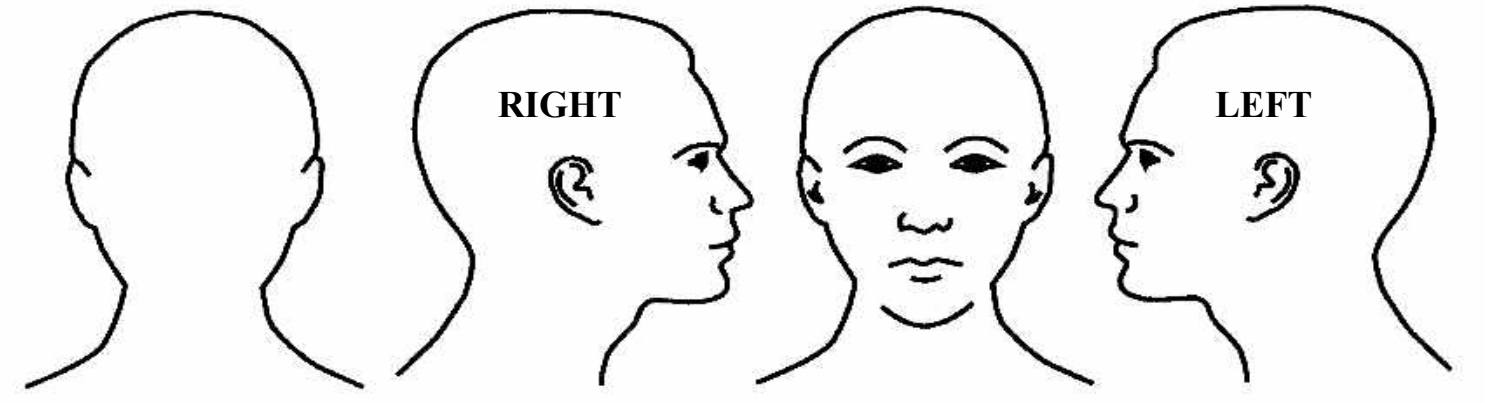
WHAT DO YOU BELIEVE TO BE THE CAUSE OF YOUR PAIN OR CONDITION?

☐ Motor vehicle accident ☐ Motorcycle accident ☐ Work related ☐ Fall ☐ Othe
☐ Playground accident ☐ Athletic endeavor ☐ Fight ☐ Injury
☐ Accident ☐ Heredity ☐ Illness ☐ Unknown

OTHER IMPORTANT INFO

WHO MAY WE THANK FOR YOUR REFERRAL?

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



LOCATION L=LEFT R=RIGHT B=BOTH SIDES		SEVERITY MILD-MOD-SEVERE	FREQUENCY OCC-FREQUENT-CONSTANT	DURATION MIN-HOURS-DAYS-WEEKS
○ L ○ R ○ B	FRONT OF HEAD	○ MILD ○ MOD ○ SEV	○ OCC ○ FREQ ○ CONS	○ MINS ○ HRS ○ DAYS ○ WKS
○ L ○ R ○ B	ENTIRE HEAD	○ MILD ○ MOD ○ SEV	○ OCC ○ FREQ ○ CONS	○ MINS ○ HRS ○ DAYS ○ WKS
○ L ○ R ○ B	TOP OF HEAD	○ MILD ○ MOD ○ SEV	○ OCC ○ FREQ ○ CONS	○ MINS ○ HRS ○ DAYS ○ WKS
○ L ○ R ○ B	BACK OF HEAD	○ MILD ○ MOD ○ SEV	○ OCC ○ FREQ ○ CONS	○ MINS ○ HRS ○ DAYS ○ WKS
○ L ○ R ○ B	TEMPLE AREA	○ MILD ○ MOD ○ SEV	○ OCC ○ FREQ ○ CONS	○ MINS ○ HRS ○ DAYS ○ WKS
○ L ○ R ○ B	EAR AREA	○ MILD ○ MOD ○ SEV	○ OCC ○ FREQ ○ CONS	○ MINS ○ HRS ○ DAYS ○ WKS
○ L ○ R ○ B	BACK OF NECK	○ MILD ○ MOD ○ SEV	○ OCC ○ FREQ ○ CONS	○ MINS ○ HRS ○ DAYS ○ WKS
○ L ○ R ○ B	FRONT OF NECK	○ MILD ○ MOD ○ SEV	○ OCC ○ FREQ ○ CONS	○ MINS ○ HRS ○ DAYS ○ WKS
○ L ○ R ○ B	CHEEK MUSCLES	○ MILD ○ MOD ○ SEV	○ OCC ○ FREQ ○ CONS	○ MINS ○ HRS ○ DAYS ○ WKS
○ L ○ R ○ B	SINUSES	○ MILD ○ MOD ○ SEV	○ OCC ○ FREQ ○ CONS	○ MINS ○ HRS ○ DAYS ○ WKS

10. PLEASE INDICATE ANY JAW PROBLEMS YOU ARE EXPERIENCING

L=LEFT R=RIGHT B=BOTH SIDES		DETAILS
○ L ○ R ○ B	JAW PAIN - OPENING	
○ L ○ R ○ B	JAW PAIN - CHEWING	
○ L ○ R ○ B	JAW PAIN - AT REST	
○ L ○ R ○ B	JAW CLICKS	
○ L ○ R ○ B	JAW LOCKS OPEN	
○ L ○ R ○ B	JAW LOCKS CLOSED	
○ L ○ R ○ B	JAW POPPING	
○ Yes ○ No	TEETH CLENCHING	
○ Yes ○ No	TEETH GRINDING	
○ L ○ R ○ B	GRINDING SOUND	
○ Yes ○ No	CURRENTLY UNDER UNUSUAL STRESS	
○ Yes ○ No	RECENT CHANGE IN LIFESTYLE	
○ Yes ○ No	RECENT CHANGE IN WORK PATTERN	
○ Yes ○ No	DO YOU DRINK FOUR OR MORE CAFFEINATED DRINKS A DAY?	
○ Yes ○ No	DO YOU USE TOBACCO?	
○ 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
○ L ○ R ○ B	BLURRED VISION	
○ L ○ R ○ B	DOUBLE VISION	
○ L ○ R ○ B	EYE PAIN	
○ L ○ R ○ B	PAIN BEHIND EYES	
○ L ○ R ○ B	PRESSURE BEHIND EYES	
○ L ○ R ○ B	SENSITIVITY TO LIGHT	
○ L ○ R ○ B	TEARING EYES	
○ L ○ R ○ B	BLOODSHOT EYES	
○ L ○ R ○ B	BUZZING IN EARS	
○ L ○ R ○ B	RINGING IN EARS	
○ L ○ R ○ B	PAIN IN FRONT OF EARS	
○ L ○ R ○ B	PAIN BEHIND EARS	
○ L ○ R ○ B	PAIN IN EARS	
○ L ○ R ○ B	HEARING LOSS	
○ L ○ R ○ B	EAR INFECTIONS	
○ L ○ R ○ B	BURNING TONGUE	
○ L ○ R ○ B	BROKEN TEETH	
○ L ○ R ○ B	CHRONIC SINUSITIS	
○ L ○ R ○ B	DRY MOUTH	
○ L ○ R ○ B	CHEEK BITING	
○ Yes ○ No	SNORING/SLEEP APNEA	

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

L=LEFT R=RIGHT B=BOTH SIDES		DETAILS
○ L ○ R ○ B	BACK PAIN - LOWER	
○ L ○ R ○ B	BACK PAIN - MIDDLE	
○ L ○ R ○ B	BACK PAIN - UPPER	
○ L ○ R ○ B	CHRONIC SORE THROAT	
○ L ○ R ○ B	FEELING OF FOREIGN OBJECT IN THROAT	
○ L ○ R ○ B	DIFFICULTY SWALLOWING	
○ L ○ R ○ B	LIMITED NECK MOVEMENT	
○ L ○ R ○ B	NECK PAIN	
○ L ○ R ○ B	NUMBNESS IN HANDS	
○ L ○ R ○ B	SCIATICA	
○ L ○ R ○ B	SCOLIOSIS	
○ L ○ R ○ B	SHOULDER PAIN	
○ L ○ R ○ B	SHOULDER STIFFNESS	
○ L ○ R ○ B	SWELLING IN NECK	
○ L ○ R ○ B	SWOLLEN GLANDS	
○ L ○ R ○ B	THYROID ENLARGEMENT	
○ L ○ R ○ B	TIGHTNESS IN THROAT	
○ L ○ R ○ 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: _____