

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 righthand column.

#	QUESTIONS	ANSWERS	NOTES - LIST QUESTION #, THEN DESCRIBE SYMPTOM DETAILS												
1	Have you noticed a change in your bite? » Do you feel like your teeth hit first on the right or left side? <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT » Do you hit more on the front teeth or more on the back teeth? <input type="checkbox"/> FRONT <input type="checkbox"/> BACK	<input type="checkbox"/> YES <input type="checkbox"/> NO													
2	Are you aware of any of the following: <table style="float:right; margin-left: 20px;"> <tr><td>Popping/Clicking</td><td><input type="checkbox"/> YES</td><td><input type="checkbox"/> NO</td></tr> <tr><td>Grinding</td><td><input type="checkbox"/> YES</td><td><input type="checkbox"/> NO</td></tr> <tr><td>Noise in the Jaw Joints</td><td><input type="checkbox"/> YES</td><td><input type="checkbox"/> NO</td></tr> </table>	Popping/Clicking	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Grinding	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Noise in the Jaw Joints	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO				
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3	Do you have difficulty or pain <input type="checkbox"/> opening wide <input type="checkbox"/> chewing?	<input type="checkbox"/> YES <input type="checkbox"/> NO													
4	When you wake up, do your jaw joint or muscles feel tight or sore?	<input type="checkbox"/> YES <input type="checkbox"/> NO													
5	Do you snore at night?	<input type="checkbox"/> YES <input type="checkbox"/> NO													
6	Does your jaw joint or muscles feel stiff, tight or tired after eating?	<input type="checkbox"/> YES <input type="checkbox"/> NO													
7	Do you grind or clench your teeth <input type="checkbox"/> at night <input type="checkbox"/> during the day?	<input type="checkbox"/> YES <input type="checkbox"/> NO													
8	Do your gums bleed after <input type="checkbox"/> brushing <input type="checkbox"/> flossing?	<input type="checkbox"/> YES <input type="checkbox"/> NO													
9	Do you experience pain in your: <table style="float:right; margin-left: 20px;"> <tr><td>Jaw</td><td><input type="checkbox"/> YES</td><td><input type="checkbox"/> NO</td></tr> <tr><td>Face</td><td><input type="checkbox"/> YES</td><td><input type="checkbox"/> NO</td></tr> <tr><td>Neck</td><td><input type="checkbox"/> YES</td><td><input type="checkbox"/> NO</td></tr> <tr><td>Shoulder and/or Arms</td><td><input type="checkbox"/> YES</td><td><input type="checkbox"/> NO</td></tr> </table>	Jaw	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Face	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Neck	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Shoulder and/or Arms	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
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10	Do you get <input type="checkbox"/> headaches <input type="checkbox"/> migraines? » How many headaches (H) and migraines (M) each week? ____ (H) / ____ (M) Each month? ____ (H) / ____ (M)	<input type="checkbox"/> YES <input type="checkbox"/> NO													
11	Do you have any <input type="checkbox"/> ringing <input type="checkbox"/> fullness in your ears?	<input type="checkbox"/> YES <input type="checkbox"/> NO													
12	Do you ever get <input type="checkbox"/> dizzy <input type="checkbox"/> sea sick?	<input type="checkbox"/> YES <input type="checkbox"/> NO													
13	Do you ever feel <input type="checkbox"/> anxiety <input type="checkbox"/> stressed? » How would you rate your stress level? <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE	<input type="checkbox"/> YES <input type="checkbox"/> NO													
14	Have you had braces or orthodontic treatment? » If Yes, when did you finish your treatment? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO													
15	Have you ever worn a <input type="checkbox"/> bite splint <input type="checkbox"/> retainer? » If Yes, when did you have this treatment? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO													
16	Have you ever had a <input type="checkbox"/> car accident <input type="checkbox"/> trauma to your head? » If Yes, describe and list dates: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO													
17	Have you ever had any sports injuries? » If Yes, describe and list dates: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO													
18	Do you restrict or avoid normal activities due to pain or symptoms? » If Yes, describe activities: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO													
19	Do you spend 4+ hours in an abnormal postural position daily?	<input type="checkbox"/> YES <input type="checkbox"/> NO													

Scoring: 1-3 "Yes" Responses = Mild unbalanced bite | 4-6 "Yes" Responses = Moderate unbalanced bite | 7+ "Yes" Responses = Severe unbalanced bite

When finished, please return to our office and review your answers with our staff.