



Orthopedic and TMJ Physical Therapy Center
Confidential Health Questionnaire
Jaw & Face Problems

Name: _____

D.O.B.: _____

Date: _____

Occupation: _____

JAW RELATED QUESTIONS

1. Does it hurt to chew? Yes No
2. Does it hurt to open wide? Yes No
3. Do you have headaches? Yes No
4. Is it difficult to swallow? Yes No
5. Are you teeth sensitive or sore? Yes No
6. Do you have implants or splints? Yes No
7. Do you have neck pain? Yes No
8. Do you have face pain Yes No
9. Is your pain constant? _____ Aching? _____ Burning? _____ Stabbing? _____ Other? _____
 Worse in the morning? _____ Afternoon _____ Evening? _____ Night? _____
10. Do you have problems with your ears? _____ Hearing? _____ Dizziness? _____ Other? _____
11. Does your jaw make a popping noise? _____ Clicking? _____ Grinding? _____ Other? _____
12. Do you ever clench or grind your teeth? _____ During the day? _____ At night? _____
13. Has your jaw ever locked or slipped out of place? _____

GENERAL HEALTH QUESTIONS.

14. Have you ever had any of the following conditions or problems? Be descriptive when appropriate.

- | | | |
|--|---|---|
| <input type="radio"/> Anemia | <input type="radio"/> Hemophilia | <input type="radio"/> Renal Disease |
| <input type="radio"/> Arthritis | <input type="radio"/> Hemorrhoids | <input type="radio"/> Respiratory problems |
| <input type="radio"/> Asthma | <input type="radio"/> High/low blood pressure | <input type="radio"/> Seizures |
| <input type="radio"/> Cataracts | <input type="radio"/> HIV, AIDS | <input type="radio"/> Skin Sensitivities or Condition |
| <input type="radio"/> Cancer | <input type="radio"/> Irritable Bowel | <input type="radio"/> Thyroid problems |
| <input type="radio"/> Chest Pains | <input type="radio"/> Kidney/Bladder Stones | <input type="radio"/> Vascular Disease |
| <input type="radio"/> Circulatory problems | <input type="radio"/> Migraines | <input type="radio"/> Musculoskeletal |
| <input type="radio"/> Constipation/Impaction | <input type="radio"/> Mitral valve prolapse | <input type="radio"/> TMJ <input type="radio"/> Shoulders |
| <input type="radio"/> Convulsions | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Neck <input type="radio"/> Hips |
| <input type="radio"/> Diabetes | <input type="radio"/> Osteomyelitis | <input type="radio"/> Back <input type="radio"/> Knees |
| <input type="radio"/> Digestive problems | <input type="radio"/> Osteoporosis | <input type="radio"/> Feet |
| <input type="radio"/> Eliminary problems | <input type="radio"/> Pacemaker | <input type="radio"/> Other |
| <input type="radio"/> Falls | <input type="radio"/> Parkinson's Disease | _____ |
| <input type="radio"/> Fractures | <input type="radio"/> Polyps | _____ |
| <input type="radio"/> Head Injuries | <input type="radio"/> Phlebitis | |
| <input type="radio"/> Heart condition | <input type="radio"/> Pregnancy Trauma | |

15. When was your last Medical exam? Within last month Within last 6 months More than 6 mo.

16. Have you ever been diagnosed for cancer, a tumor, or noticed any lumps or swellings? Yes No

17. Do you Smoke? Yes No

18. Do you drink alcohol (if so list # per week)? No. _____ Beer. _____ Wine. _____ Spirits.

19. Education High School College Graduate Professional Training

20. Are you currently under the care of a physician/chiropractor/therapist/acupuncturist, counselor, etc. ?

Provider's Name & Specialty

21. Please list all medications you are currently taking (prescription and over the counter)?

Name & Dosage

Reason for taking

22. Indicate what amount you drink of the following in a typical day. ___ Water (8oz.) ___ Juice (8oz.)

___ Coffee (cups) ___ Tea (cups) ___ Soda (8oz.)

23. Please describe your diet.

24. Allergies: medication, food or other

25. Have you ever been treated for any of the following:

Anxiety

Nervous Problems

Drug Addiction

Depression

Alcoholism

26. Do you experience:

Numbness/tingling/weakness in anywhere in your body

Urinary leaking or urge with exercise, laughing, coughing, or on the way to the bathroom

Pain with urination or sexual activity

27. Please list any past injuries, accidents and surgeries (include dates if possible):

28. Have you ever seen a physical therapist before? Yes No

29. Please list exercise, sports, hobbies or musical instruments

30. Please Describe your sleeping habits (Snoring, # of hours, position, # of pillows) .

31. How did you hear about our clinic?

32. In your own words please describe your problem:

33. **Life Impairment:** What are your feelings about your problem on a scale of 1 to 10?

No Impairment 0 1 2 3 4 5 6 7 8 9 10 Severe Impairment