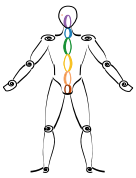

Orthopedic and TMJ Physical Therapy Center
Confidential Health Questionnaire

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.

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

15. Hours of sitting per day (computer + driving) _____
16. When was your last Medical exam? ❍Within last month ❍Within last 6 months ❍ More than 6 mo.
17. Have you ever been diagnosed for cancer, a tumor, or noticed any lumps or swellings? ❍Yes ❍No

18. Do you Smoke? ❍Yes ❍No

19. Do you drink alcohol (if so list # per week)? ❍ No. ____Beer. ____Wine. ____Spirits.

20. Education ❍ High School ❍College ❍Graduate ❍Professional Training

21. Are you currently under the care of a physician/chiropractor/therapist/acupuncturist, counselor, etc. ?
Provider's Name & Specialty
_____
_____
_____

22. Please list all medications you are currently taking (prescription and over the counter)?
Name & Dosage Reason for taking
_____ _____
_____ _____
_____ _____

23. Indicate what amount you drink of the following in a typical day. ____Water (8oz.) ____Juice (8oz.)
____ Coffee (cups) ____ Tea (cups) ____ Soda (8oz.)

24. Please describe your diet._____
_____
_____

25. Allergies: medication, food or other _____
_____

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

❍ Anxiety ❍ Nervous Problems ❍ Drug Addiction
❍ Depression ❍ Alcoholism ❍ None of the above

27. 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
❍ None of the above

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

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

30. Please list exercise, sports, hobbies or musical instruments_____
_____
_____
_____

31. Check all that apply: ❍ Face/brow lift ❍ Cheek/chin implants ❍ Breast augmentation/reduction

32. Please describe your sleeping habits (Snoring, # of hours, position, # of pillows) .____
_____

33. How did you hear about our clinic?_____

34. In your own words please describe your problem: _____
_____
_____
_____
_____
_____