COLUMBIA REGIONAL CENTER *for* TMJ & OROFACIAL PAIN

Patient Health Questionnaire

Today's Date: ______________

Demographic Information

Last Name: ______________________ Middle Initial: ______ First Name: ______________________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Age: __________ Date of Birth: ______________ SSN: ______________ Sex: ☐ Male ☐ Female

Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Decline

Occupation: ____

Responsible Party/Legal Guardian (if different than patient): ______________ Relationship to Patient: ______________

Contact Information

Address: ______________________ Address 2: ______________________

City: ______________________ State: __________ Zip Code: ______________

Email: ______________________ Employer: ______________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Referral Information - how did you hear about us?

Referral Name/Source: ____

Referral Type: ☐ Doctor ☐ Dentist ☐ Specialist ☐ Patient ☐ Other ______________________

Provider Information

Dental Provider Office: ______________________ Last Visit: ______________

Dentist Name: ______________________ Office Phone: ______________

City: ______________________ State: __________ Zip Code: ______________

Primary Care Physician Office: ______________________ Last Visit: ______________

Doctor Name: ______________________ Office Phone: ______________

City: ______________________ State: __________ Zip Code: ______________

Additional Provider Office (if applicable): ______________________ Last Visit: ______________

Doctor Name: ______________________ Office Phone: ______________

City: ______________________ State: __________ Zip Code: ______________

Additional Provider Office (if applicable): ______________________ Last Visit: ______________

Doctor Name: ______________________ Office Phone: ______________

City: ______________________ State: __________ Zip Code: ______________

For Office Use Only - Date of Completion: ______________

Patient Initials: ________

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FOR TMJ & OROFACIAL PAIN
1363 Columbia Park Trail, Suite 101
Richland, WA 99352

Current Symptoms

Reason(s) for this appointment: ☐ Pain ☐ Sleep/Airway ☐ Orthodontics ☐ Other ____________________

Please number your chief complaint as 1 and all other complaints starting at 2 and increasing numerically:

___Back Pain
___Difficulty Closing Mouth
___Dizziness
___Dyskinesia
___Ear Congestion
___Ear Pain
___Ear Stuffiness
___Eye Pain
___Facial Pain
___Headache (inside head)
___Headache (outside head)
___Jaw Joint Locking
___Jaw Joint Noises
___Jaw Pain
___Limited Ability to Open
___Muscle Twitching
___Neck Pain
___Nerve Pain
___Numbness
___Pain When Chewing
___Shoulder Pain
___Sinus Congestion
___Throat Pain
___Tinnitus (Ringing in Ears)
___Vision Problems
___Acid Indigestion
___Affecting Sleep Partner
___Difficulty Falling Asleep
___Dry Mouth Upon Waking
___Fatigue
___Feel Unrefreshed in Morning
___Frequent Heavy Snoring
___Frequent Tossing & Turning
___Kicking/Jerking Legs Repeatedly
___Morning Headaches
___Morning Hoarseness in Voice
___Night Sweats
___Nighttime Choking Spells
___Nighttime Urination
___Repeated Awakening
___Short of Breath
___Sore Jaw Upon Waking
___Swelling in Ankles/Feet
___Teeth Crowding
___Teeth Grinding
___Told I Stop Breathing During Sleep
___Unable to Tolerate CPAP
___Vivid Dreams

What is your level of head, neck, and facial pain? *0 = no pain to 10 = worst possible pain:*

Currently: ____________ At its best: ____________ At its worst: ____________

What results are you seeking from treatment? ____

____

Please check any dental symptoms that you are currently experiencing:

___Changes in bite
___Dental Changes
___Teeth Crowding
___Teeth Sensitivity
___Teeth Spacing
___None

Any symptoms not listed above? ____

____

____

In which position do you sleep? ☐ back ☐ side ☐ stomach ☐ varies
Where do you sleep? ☐ bed ☐ chair ☐ couch ☐ other
Do you have a bed partner? ☐ yes ☐ no
Is it easy for you to fall asleep? ☐ yes ☐ no
How many times do you wake during the night? _____
Do you feel rested upon waking? ☐ yes ☐ no
Has anyone ever told you that you stop breathing during sleep? ☐ yes ☐ no
Have you ever had a sleep study? ☐ yes ☐ no
If yes: Date: ___________ Location: _______________

Patient Initials: ________

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Medications

Please list all medications you are currently taking and the reason you are taking the. Include prescription, over the counter, vitamins, herbs, etc. (Please attach additional sheet if necessary)

Medication	Dosage	Reason for Taking

Previous treatments/medications for the condition we are evaluating:

Treatment/Medication	Doctor/Provider	Approximate Date of Treatment

☐ TMJ & Sleep Therapy Centre has my permission to obtain my complete medication history, including electronic prescription submission

Allergies

Please check any and all medications or substances that have caused an allergic reaction:

___Anesthetics
___Antibiotics
___Aspirin
___Barbiturates
___Codeine
___Iodine
___Latex
___Metals
___Penicillin
___Plastic
___Sedatives
___Sulfa

Other:______________________________

Medical History

Have you had prior orthodontic treatment? ☐ yes ☐ no

Have you had sustained injury to: ☐ head ☐ face ☐ neck ☐ teeth

Other:______________________________

Please indicate if you have had any of the following:

___General Anesthesia
___Adenoids Removed
___Tonsils Removed
___Jaw Joint Surgery
___Orthognathic Surgery
___Oral Surgery
___Removal of Wisdom Teeth
___Nasal Surgery

Other Surgeries:______________________________

Do you have trouble breathing through your nose? ☐ yes ☐ no

Are you currently pregnant? ☐ yes ☐ no

Do you drink 4 or more cups of coffee per day? ☐ yes ☐ no

Do you smoke tobacco? ☐ yes ☐ no

Do you consume alcohol? ☐ yes ☐ no

if yes: ☐ habitually ☐ socially

Do you take any sedatives/medications/supplements to help yourself fall asleep at night? ☐ yes ☐ no

If yes, what: ______________________________

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Medical History, Continued

Have you ever experienced: ___Physical Abuse ___Verbal Abuse ___Emotional Abuse ___Sexual Abuse ___None
(Optional - check applicable)

If yes, please explain (optional):______________________________

Do you have or have you experienced any of the following?

___AIDS/HIV
___Anemia
___Anxiety
___Asthma
___Birth Defects
___Bleeding Easily
___Bruising Easily
___Cancer
___Chronic Fatigue
___Cold Hands and Feet
___Depression
___Diabetes
___Difficulty Breathing at Night
___Difficulty Concentrating
___Dizziness
___Eating Disorder
___Ehlers-Danlos Syndrome (EDS)
___Emphysema
___Epilepsy
___Excessive Thirst
___Fainting
___Fibromyalgia
___Fluid Retention
___Frequent Awakening at Night
___Frequent Colds/Flus
___Frequent Cough
___Frequent Ear Infections
___Frequent Sore Throat
___Gastroesophageal Reflux (GERD)
___Glaucoma
___Hay Fever
___Hearing Impairment
___Heart Disorder/Heart Attack
___Heart Murmur
___Heart Pacemaker
___Heart Palpitations
___Heart Valve Replacement
___Hemophilia
___Hepatitis
___High Blood Pressure
___History of Substance Abuse
___Huntington's Disease
___Hypoglycemia
___Insomnia
___Intestinal Disorder
___Irregular Heartbeat
___Kidney Disease
___Leukemia
___Liver Disease
___Low Blood Pressure
___Memory Loss
___Meniere's Disease
___Migraines
___Mitral Valve Prolapse
___Muscle Aches
___Muscular Dystrophy
___Muscle Fatigue
___Muscle Spasms
___Muscle Tremors
___Multiple Sclerosis
___Nervous System Disorder
___Neuralgia
___Osteoarthritis
___Osteoporosis
___Ovarian Cyst
___Parkinson's Disease
___Poor Circulation
___Postural Orthostatic Tachycardia Syndrome (POTS)
___Psychiatric Care
___Recent Weight Gain
___Recent Weight Loss
___Rheumatoid Arthritis
___Rheumatoid Fever
___Scarlet Fever
___ Seizures
___Shortness of Breath
___Significant Daytime Drowsiness
___Sinus Problems
___Skin Disorder
___Slow Healing Sores
___Sleep Apnea
___Speech Difficulties
___Stroke
___Swollen, Stiff, or Painful Joints
___Thyroid Problem
___Tired Muscles
___Tuberculosis
___Urinary Tract Disorder

Does your family have a history of similar conditions, symptoms, or diseases? ☐ yes ☐ no

If yes, who:______________________________

Have you been prescribed a CPAP? ☐ yes ☐ no
Do you use it as prescribed? ☐ yes ☐ no
Have you had a previous oral appliance, mouthguard, splint, retainer? ☐ yes ☐ no
Do you use it as prescribed? ☐ yes ☐ no
How many hours of sleep, on average, do you get per night? _____
How many hours of sleep, on average, during the day? _____
Do you ever cough, gasp, or snort upon waking? ☐ yes ☐ no

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Currently Experiencing

Are you currently experiencing head pain? ☐ yes ☐ no

If yes, please indicate all that apply:

	Location			Time Frame		Severity			Duration			Frequency		
	Left	Right	Bilateral	Recent	Chronic (over 6 mo.)	Mild	Moderate	Severe	Min.	Hrs.	Days	Occasional	Frequent	Constant
Temple Area (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Back of Head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Forehead (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Top of Head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
General Head Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are you currently experiencing jaw conditions? ☐ yes ☐ no

If yes, please indicate all that apply:

Jaw pain with opening	☐ left	☐ right
Jaw pain when chewing	☐ left	☐ right
Jaw pain at rest	☐ left	☐ right
Jaw sounds with opening	☐ left	☐ right
Jaw sounds when chewing	☐ left	☐ right
Jaw sounds at rest	☐ left	☐ right

Please indicate if you have had any of the following:

___Jaw Locks Closed

___Jaw Locks Open

___Daytime Teeth Clenching/Grinding

___Nighttime Clenching/Grinding

___Blurred Vision

___Double Vision

___Pain/Pressure behind eyes

___Extreme Sensitivity to light

___Wear Glasses or Contact Lenses

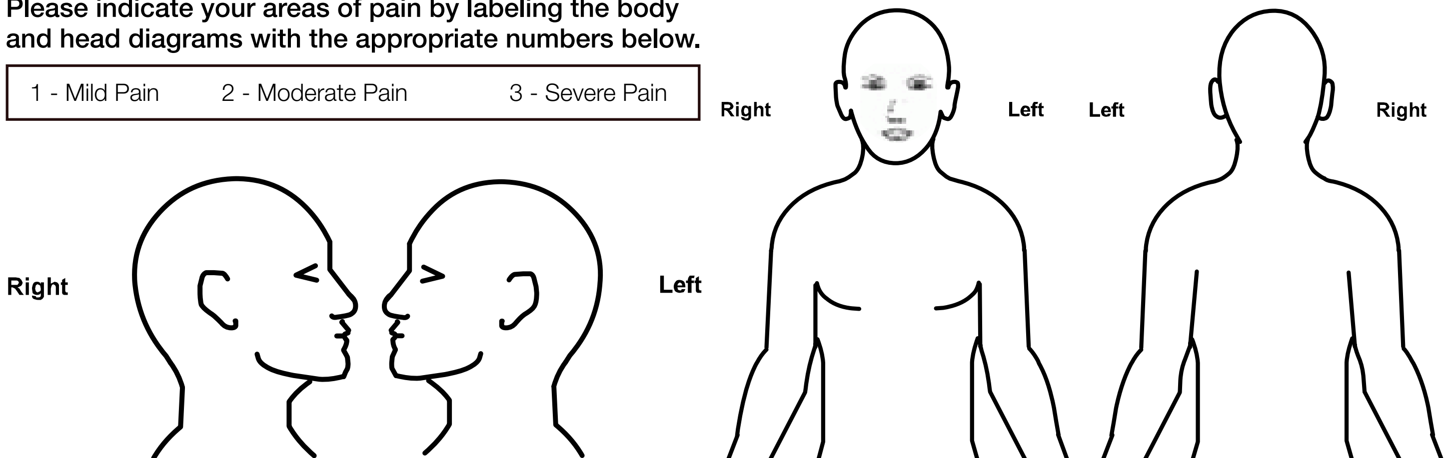
Are you currently experiencing any ear related conditions? ☐ yes ☐ no

If yes, please indicate all that apply:

Ear Congestion	☐ left	☐ right
Ear Pain	☐ left	☐ right
Hearing Loss	☐ left	☐ right
Itchiness or Stuffiness in Ears	☐ left	☐ right
Pain Behind the Ear	☐ left	☐ right
Pain in Front of the Ear	☐ left	☐ right
Recurrent Ear Infections	☐ left	☐ right
Ringing in the Ear	☐ left	☐ right

Please indicate your areas of pain by labeling the body and head diagrams with the appropriate numbers below.

1 - Mild Pain 2 - Moderate Pain 3 - Severe Pain



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Please indicate if you have had any of the following:

___Chronic Sore Throat
___Difficulty Swallowing
___Swollen Gland
___Thyroid Enlargement
___Tightness in Throat
___Constant Feeling of Foreign Object in Throat
___Limited Movement of Neck
___Neck Pain
___Numbness in hands/fingers
___Swelling in the neck
___Shoulder Pain
___Shoulder Stiffness
___Tingling in hands or fingers
___Lower Back Pain
___Upper Back Pain
___Middle Back Pain
___Scoliosis
___Sciatica
___Chronic Sinusitis
___Broken Teeth
___Dry Mouth
___Frequent Biting of the Cheek
___Burning Tongue Sensation

Symptom History

On what date, or approximate date, did your condition/symptoms first occur?________________________________

Can you relate your pain/condition to a motor vehicle accident or traumatic injury? ☐ yes ☐ no

If yes, please explain: ________________________________

Does any family member have a sleep breathing disorderor Obstructive Sleep Apnea? ☐ yes ☐ no

If yes, who: ________________________________

Does any family member have the same or a similar problem? ☐ yes ☐ no

If yes, please explain: ________________________________

Additional Information

Is there anything else you would like us to know?

____
____
____
____
____
____
____
____

Signature

I agree, the above information is accurate and complete to the best of my knowledge.

Patient Signature: ________________________________Date: ________________

Parent/Guardian Signature: ________________________________Date: ________________