

Section I: Patient Questionnaire

Patient Name _____ Date _____
Address _____ Phone _____
Employer Address _____ Phone _____
Date of Birth _____ Age _____ Sex: Male/Female Married _____ Single _____

Name of Spouse _____
Parents Name (If child) _____
If patient is a child over 18: School _____ Year _____

Medical Insurance Co _____ Plan # _____
Patient's relationship to subscriber Self Spouse Child Other _____
Subscriber's Name _____ SS # _____
Subscriber's Address _____ Phone _____
Employer _____ Union or Local _____

Referred By _____

What are your specific complaints? List from most to least important.

- 1) _____
- 2) _____
- 3) _____

When did you first experience the problem for which you are seeking help? Date _____

In order list ALL Physicians, therapists or health care providers you have consulted for this problem:

In YOUR opinion, what initiated your present condition (chief complaint)? _____

What aspect of your condition concerns you most? _____

Are you presently involved with any litigation? NO YES

If so, Attorney's name, Address, phone _____

Patient's Name _____

SYMPTOM CHECK LIST

Please check any of the following symptoms which apply to you. (L = left; R = right)

HEADACHES

___ Migraines ___ Tension Headaches ___ Other _____

How often? _____

Top of Head L_____ R_____ Temples L_____ R_____

Forehead L_____ R_____ Behind Eyes L_____ R_____

Back of Head (occipital) L_____ R_____ L_____ R_____

Pain in neck L_____ R_____ Pain in shoulder L_____ R_____

Pain in ear L_____ R_____ Ear congestion L_____ R_____

Dizziness (Vertigo) _____ Tinnitus (Ringing sound in ears) L_____ R_____

Pain in jaw joint L_____ R_____ Facial Pain (nonspecific) L_____ R_____

Clicking or popping sound in joint L_____ R_____ Grating sound in Joint L_____ R_____

Partial inability to open mouth No_____ Yes_____ Constant _____ Sporadic _____

Face muscle twitch No_____ Yes_____

Difficulty swallowing No_____ Yes_____

Difficulty breathing through nose No_____ Yes_____

Difficulty Chewing No_____ Yes_____

Loose teeth (specify) _____

OCCLUSAL HABITS:

___ Clenching ___ AM ___ PM ___ Grinding on Teeth ___ AM ___ PM

___ Teeth hit in front first ___ Cheek Biting

___ Gum Chewing ___ Pipe Smoking

___ Pencil Biting ___ Nail Biting

___ Other: _____

POSTURAL HABITS:

___ Phone Cradling ___ Leans chin on hand

___ TV watching ___ Heavy Lifting

___ Shoulderbag

___ Other: _____

Patient's Name _____

Date of last complete Medical Exam? Month _____ Year _____

Family Physician _____ Specialty _____

Phone _____ Diagnosis/Treatment: _____

Address _____

Comments: _____

Other Physidcian _____ Specialty _____

Phone _____ Diagnosis/Treatment: _____

Address _____

Comments _____

Weight _____ Height _____

MEDICATIONS CURRENTLY TAKING

Medications	Quantity	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check YES or NO and provide details if requested:

Are you currently under medical treatment? NO YES
Explain _____ Treating Physician _____

Do you have Heart trouble? NO YES

Do you have Pacemaker? NO YES

Have you had Rheumatic Fever? NO YES When? _____

Do you have High Blood Pressure? NO YES
How is it controlled? _____

Have you had Pain in your Chest or Shortness of Breast? NO YES

Do you Ankles ever Swell? NO YES

Have you ever been told you are Anemic? NO YES

Have you ever had Stroke? NO YES When? _____

Do you have Diabetes? NO YES
How is it controlled? _____

Are you subject to Fainting or Dizziness? NO YES

Do you have any Nervous Disorders? NO YES

Are you Allergic to any Medication or Drugs? NO YES
What? _____

Do you have Asthma, Hay Fever or Allergies? NO YES

Do you have Tonsil or Adenoid problems? NO YES

Have you had Tonsil or Adenoid surgery? NO YES

Have you had Tuberculosis? NO YES

When? _____

Have you had Infectious Hepatitis? NO YES

When? _____

Do you have Arthristis? NO YES

Have you ever had a Tumor or Cancer? NO YES

How was it treated _____

Have you had any Major Operations? NO YES

What for? _____

Have you had a Significant Weight change in the last year NO YES

Lost ___ lb. Gained _____ lb.

Is you diet medically supervised? NO YES

For what purpose? _____

Do you take Vitamin or Mineral supplements? NO YES

Do you become Fatigued easily? NO YES

Do you sleep well? NO YES

Do you snore? NO YES

Do you have trouble breathing when asleep? NO YES

Do you sleep with the bed elevated? NO YES

Do you frequently not eat breakfast? NO YES

Do you take more than one alcoholic drink per day? NO YES

How much? _____

Do you smoke or use Tobacco? NO YES

Have you ever experienced problems of prolonged bleeding,
either from a cut, or a dental procedure such as cleaning? NO YES

Have you ever been involved in a serious accident? NO YES

When? _____

Nature of injuries? _____

Did the Symptoms start after this accident? NO YES

Explain _____

Is the Symptom(s) due to an illness, injury, or work related
accident NO YES

Place of accident or injury? _____

Date and Time of accident _____

Explanation _____

HAVE YOU HAD:

Recent X-rays? Date/Type - Explain _____

