Welcome to the REstore TMJ & Sleep Therapy!

Thank you for choosing our office for the diagnosis of your Headache, Facial Pain, Temporomandibular Joint Disorder, or Sleep Breathing Disorder. We look forward to helping you.

You will have access to the latest diagnostic procedures and the expertise of a Texas-licensed dentist who specializes in the treatment of TMD, Orofacial pain, and Dental Sleep Medicine. Our practice adheres to a research-based model, in alignment with the American Academy of Orofacial Pain and the American Academy of Dental Sleep Medicine. Our highly trained and certified team will answer any questions that you may have and assist you in an appropriate manner during the history and exam procedure, as well as in your treatment.

Please bring any previously obtained advanced imaging or radiology reports (X-rays, CT scans, MRIs), recent blood work, and any oral appliances you are currently using to your appointment.

There are many causes of temporomandibular joint disorders and chronic orofacial pain, including nerve disorders, headache, musculoskeletal/postural issues, systemic issues, congenital conditions, sleep disturbance, and joint disorders. New patients receive a comprehensive examination for head, neck, and facial pain. This includes a thorough review of the patient's pain history, cervical evaluation, and examination of TMJ function. A cranial nerve evaluation may be conducted as needed. An oral evaluation, thorough muscle palpation of the head and neck muscles, and a sleep breathing disorder assessment are also performed. These examinations are necessary to determine the cause or source of the pain, which will help identify the most effective treatment protocols. A CT, MRI, or blood tests may also be ordered as part of this comprehensive evaluation.

Since chronic pain can have an overwhelming impact on normal function and may be related to sleep disruption, new patients must fill out psychological and sleep-related questionnaires. We may recommend additional treatments to address the psychological and stress components of the pain, refer you to a sleep physician for an evaluation, or recommend a physical therapist or other adjunct care providers as appropriate.

Chronic pain is often multi-factorial, and treatment usually takes several visits to gain improvement. Since pain and other symptoms may have been present for some time, the treatments also require time to take effect on the pain. There is no “magic bullet” for chronic pain. Treatments differ depending on the type of pain and may involve splint therapy, physical medicine modalities, nerve blocks, joint lavage, as well as oral and topical medications.

Our ability to assist you will depend on your thoroughness in completing the assessment questionnaires included in this packet. This will benefit you directly as it dramatically enhances the accuracy of our diagnosis for your medical condition. Most Facial Pain or TMJ disorders are complex in nature and require a significant amount of time to understand. Although the exact cause of temporomandibular joint disorders (TMDs) and chronic orofacial pain is uncertain, it has been suggested that the psychological profile, pain amplification, general health, and global symptoms play an influential role in the origin of painful TMDs. TMDs appear to be influenced by biological, psychological, and social factors. They can be triggered by several risk factors, including genetic factors, autonomic regulation, physical health, pain modulation, hormonal changes, the patient's sex, psychological factors, individual beliefs, coping abilities, anxiety, fear, depression, sleep disturbances, and mood changes. Other factors can include personal relationships, communication, culture, socioeconomic status, and school or work environments

Due to the way the insurance industry handles specialty orofacial pain practices like ours, our office is not in-network with any medical or dental healthcare insurance providers. Diagnosis and treatment of chronic orofacial pain require medical codes and are not covered by dental insurance. We will, however, assist you in filing a claim with your medical insurance or provide you with an insurance claim form at your appointment, allowing you to submit it to your insurance company, except for Medicare. We have opted out of Medicare, and neither our office nor the patient can submit any claims to them. Any reimbursement from your insurance will come directly to you to offset the cost of treatment. We work very hard to keep our fees as low as possible. One way we accomplish this is by having our patients pay at the time services are rendered. We offer our patients several convenient payment options: cash, debit cards, checks, Visa, MasterCard, American Express, Discover cards, and interest-free long-term payment plans through CareCredit.

As you complete the following forms, please ensure that you sign where indicated. We look forward to meeting you for your scheduled consultation. If you have any questions or concerns, please don't hesitate to contact any member of our team. They will be delighted to assist you. We have set aside a significant amount of time for your new patient appointment. If there are any changes to your plans, we would appreciate at least 24 hours' notice so we can assist others waiting to be seen in our office for an assessment of their medical condition.

Sincerely,

Dr. Phillips, Dr. FischerHahm, and Team

REstore
TMJ & Sleep Therapy

CONFIDENTIAL PATIENT INFORMATION **PLEASE PRINT ALL INFORMATION**

Name _____ (First) _____ (Middle) _____ (Last) Gender ☐ Male ☐ Female

Nickname _____ Marital Status ☐ Married ☐ Single ☐ Minor ☐ Student

Address _____ Home telephone _____

City _____ State _____ Zip _____ Office telephone _____

Cell# _____ Email Address _____

Birth date _____ Social Security _____ Texas Drivers Lic. _____

Place of Employment (or school) _____

Address _____

City _____ State _____ Zip _____ Occupation _____

Physician. _____ Address _____

City _____ State _____ Zip _____ Telephone _____

Dentist _____ Address _____

City _____ State _____ Zip _____ Telephone _____

Spouse name _____ (First) _____ (Middle) _____ (Last)

Responsible Party Information: Same as Patient check this box ☐ OR If minor fill out the following:

Party #1

Name _____ (First) _____ (Middle) _____ (Last)

Address _____

City _____ State _____ Zip _____ Home phone _____

Office telephone _____ Birth date _____ Social Security # _____

Texas Drivers Lic. _____

Place of Employment (or school) _____ Occupation _____

Address _____

Party #2

Name _____ (First) _____ (Middle) _____ (Last)

Address _____

City _____ State _____ Zip _____ Home phone _____

Office telephone _____ Birth date _____ Social Security # _____

Texas Drivers Lic. _____

Place of Employment (or school) _____ Occupation _____

Address _____

Whom may we thank for referring you to our office? _____

PLEASE HAVE YOUR INSURANCE CARD AVAILABLE TO MAKE A COPY
PLEASE SIGN AND DATE AT THE BOTTOM

- Please list the names of family members (i.e. spouse), attorney or other persons, if any, whom we may inform about your medical condition, diagnosis and financial responsibility.

_____

_____

_____

- Please list the health care providers whom we may inform about your medical condition.

  Referring Doctor: _____

  Dentist: _____

  Physician: _____

  Other: _____

- What is the Pharmacy you would want any medications to be sent to for pick up?

  Pharmacy name: _____ Address _____

  City _____ State _____ Zip _____ Pharmacy phone: _____

Should further information be needed for my treatment with this office, I give consent to ask my respective health care provider or agency to release any information to you. ☐ Yes ☐ No

I consent to the use of my medical record for the purpose of educating other healthcare providers. However, my identity will be kept confidential so that I will not be identified. ☐ Yes ☐ No

We will provide you with the necessary information to follow up with your insurance company.

Please read carefully:

(Your signature below means you agree)

- I understand that all charges incurred in this office are due at the time they are rendered.
- I understand that these fees may exceed the limit allowed by my insurance company.
- I understand that this office is not a provider for my insurance company, including Medicare, Medicaid, Workman's Comp, Champus or TriCare.
- I understand that I will be responsible to file my claim to my insurance company.
- I authorize the release of medical records or other information needed for the insurance claim.
- I will be provided with fees prior to receiving treatment and I understand that I have the option to seek treatment from a participating provider.

The name and phone number of your nearest relative or close friend to notify in case of an emergency.

_____ _____

Name of relative or close friend Phone Number:

_____ _____

Patient/Parent Signature: Date:

REstore
TMJ & Sleep Therapy

INFORMED CONSENT FOR
CONE BEAM COMPUTERIZED TOMOGRAPHY SCAN
&
EVALUATION BY A DENTAL RADIOLOGIST

Patient Name _____ _____ _____ _____
First Middle Last Date of Birth

I HEREBY AUTHORIZE KATHERINE S. PHILLIPS DDS, YOUNGCHOON J. FISCI-IERHAHM DMD, AND WHOMEVER THEY MAY DESIGNATE AS THEIR ASSISTANTS, TO PERFORM UPON ME A CONE BEAM X-RAY DENTAL EXAMINATION (CONE BEAM COMPUTERIZED TOMOGRAPHY SCAN) AS PART OF MY DENTAL CARE AND TREATMENT.

General description of procedure:

A CBCT scan is usually referred to as cone beam computerized tomography. This is an x-ray technique similar to a medical CT scan. The technique produces images of your body that depicts internal structures in cross sections rather than the overlapping images typically produced by conventional x-ray exams. Conventional x-rays of your mouth limits your dentist to evaluating anatomical structures in a 2 dimensional view. Your diagnosis and treatment planning can be enhanced by a more complete understanding of complex 3-dimensional anatomy. The relationship of anatomical structures in three dimensions is important in assessing your condition as well as treatment planning for dental implants, surgical extractions, endodontic treatment, oral surgery or advanced dental restorative procedures. CT scans may be useful in evaluating and potentially diagnosing conditions which cannot be properly seen with conventional x-rays.

Risks:

CBCT scans, like conventional x-rays expose you to radiation. The dose (0.087 mSv) is approximately the same as U.S. background radiation equivalents: 11 days exposure to natural radiation; or a single plane flight from Los Angeles to London; or 11 single tooth dental x-rays. This machine is registered with and certified by the Texas State Department of State Health Services. The Registration number is R43627.

The Cone Beam dental examination may or may not reveal coincidental medical findings unrelated to my dental condition, dental care and dental treatment. The purpose is a diagnostic procedure intended solely to facilitate diagnosis to my dental condition, my dental care, and my dental treatment.

The Cone Beam dental examination will be evaluated solely for the purposes associated with the dental procedures discussed in your treatment plan. The data obtained during this study may result in incidental findings unrelated to my dental condition, dental care and dental treatment and are beyond the scope and purpose of my dental condition.

CBCT scans are NOT recommended for pregnant women because of danger to the fetus. (Initial below as appropriate.)

- ☐ I am not pregnant
- ☐ I am pregnant
- ☐ I am unsure whether I am pregnant

Alternatives:

An alternative to CBCT scans are conventional X-rays, however, they have limitations previously noted.

I consent to the above treatment after having been advised of the risks, advantages and disadvantages of the treatment and the consequences if this treatment were withheld.

I consent to the above treatment plan after having been advised of the alternate plans of treatment available and the known material risks, advantages and disadvantages of the alternative treatment.

I realize CBCT is appropriate and desired by me and is medically necessary for my treating doctor to diagnose my medical concern. I am aware that the diagnostic imaging procedure which I will undergo may potentially reveal pathology outside the scope of my dentist's expertise and the information provided does not guarantee a specific diagnosis or clinical outcome. I acknowledge that no guarantees have been made to me concerning the results of the diagnosis or the proposed clinical procedure.

I have provided as accurate and complete a medical and personal history as possible, including those antibiotics, drugs, medications and foods to which I am allergic. I will follow any and all instructions as explained and directed.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medical condition, contemplated and alternative treatment and procedures, and the risk and potential complications of the contemplated and alternative treatment and procedures, prior to signing this form.

I understand that my dentist is not a physician, or a specialist qualified to make the assessment concerning anatomy and pathology beyond your mouth and jaw. As a result, you may elect to have the data evaluated by a physician or radiologist.

I also have been told that I may elect to send the CT studies on my behalf to a head and neck dental radiologist (Dental Radiologist Specialist) to evaluate the study for additional findings outside the scope of my dental exam.

The cost associated with this additional interpretation will be beyond the fees charged for the CBCT scan itself.

Please mark an "✓" in box for statement chosen:

☐ I want this scan to be interpreted by a Dental Radiologist and will be charged an additional fee of $135. It will then be the responsibility of the Dental Radiologist to determine if there is any pathology in the scan. I understand that I will receive a written report and recommendations for any further evaluation.

☐ I will not hold the doctor responsible for any pathology in the scan other than in the Temporomandibular joints. But if the doctor has any concerns that need further evaluation by a Dental Radiologist, I will approve this scan being sent to be interpreted by a Dental Radiologist, for which I will be charged an additional fee of $135. It will then be the responsibility of the Dental Radiologist to determine if there is any pathology in the scan. I understand that I will receive a written report and recommendations for any further evaluation.

☐ I do not want this scan to be read by a Dental Radiologist, and further, I will not hold the doctor responsible for any pathology found in the scan other than that in my Temporomandibular Joints. I have the right to change my mind at any time in the future and have my scan read by a Dental Radiologist and will be charged an additional fee of $135. It will then be the responsibility of the Dental Radiologist to determine if there is any pathology in the scan. I understand that I will receive a written report and recommendations for any further evaluation.

I consent to the taking of a cone beam computerized tomography scan limited to images of my head and upper neck. I acknowledge that the doctor using these images for the diagnosis of my medical concern is not a Dental Radiologist. I understand that the interpretation of the scan by my treating doctor will be limited to the Temporomandibular joints. The doctor may see other possible concerns that will implement a referral for further evaluation by a medical specialist, or possible pathology that would require an interpretation by a Dental Radiologist. I also give permission and consent to my doctor to share clinical images taken from this study with other persons for the purpose of gaining additional insight on my clinical condition, for educational purposes and/or the development of the medical/dental field.

Patient/Parent Signature: _____ Date: _____

Disclosure of provider Ownership

Please be informed that Dr. Katherine S. Phillips has direct and indirect financial ownership relations, and may receive remuneration directly or indirectly from the entities of: Sleep Tight Diagnostic Laboratory. Decisions regarding the admissions, recommendations, referrals, or any other form of arrangement for utilization by patients of Dr. Phillips of specific services or facilities are made with regard to the best interest of each individual patient. You have the right to choose the provider of your health services. You will not be treated differently by your Dr. Phillips if you choose to obtain other health care services. If you have any questions concerning this notice, please feel free to ask Dr. Phillips.

Acknowledgement of Notice of Privacy Practice

I hereby acknowledge that I have read, received (upon request) and accept the terms of Restore TMJ & Sleep Therapy, PLLC's Notice of Privacy Practices (HIPPA consent form)

Patient/Parent Signature: _____ Date: _____

Documentation of Good Faith Effort

To obtain patient's acknowledgement that they received provider's Notice of privacy practice

(For use when acknowledgement cannot be obtained from the patient)

The patient presented to the office on _____ (date) and was provided with a copy of Restore TMJ & Sleep Therapy's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Patient was unable to sign or initial because: _____
- ☐ The patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason:

_____

Signature of employee completing the form _____ Date: _____

Note:

Providers are required to make good faith efforts to obtain acknowledgement that each patient has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider's Notice of Privacy Practices, the provider should document the "Good Faith Efforts" taken to obtain such acknowledgement. -The regulation does not specify how those "Good Faith Efforts" should be documented.

Please check the following questions that apply to you:

- ☐ Do you snore? ☐ Mild ☐ Moderate ☐ Severe? How many years? _____
- ☐ Do you snore: ☐ On your side? ☐ On your back? Usual position: ☐ back ☐ side ☐ stomach
- ☐ Do you fall asleep when reading, watching TV, or other passive activities?
- ☐ Do you fight sleepiness on the job or when driving?
- ☐ Do you often wake with headaches?
- ☐ Do you ever wake choking or gasping for air?
- ☐ Do you often wake up feeling tired, fatigued, and unrefreshed?
- ☐ Do you take naps during the day? If so, for how long? _____
- ☐ Would you take a nap if you could?
- ☐ Do you have trouble falling asleep? On average, how long to go to sleep? _____
- ☐ Do you have trouble staying asleep throughout the night?
  Number of times you wake up at night _____
  Length of time getting back to sleep after you wake up at night _____
- ☐ Do you have restless or "creepy, crawly" leg feelings?
- ☐ Do you experience unusual behaviors just before, during or after sleep?
- ☐ Do you ever wake up feeling paralyzed?
- ☐ Have you ever experienced a sudden loss of strength in your arms/legs during the day?
- ☐ Do you feel unhappy or discouraged about your sleep?
- ☐ Does your sleep problem affect your family life, work performance?
- ☐ How many caffeinated beverages do you have each day? _____
- ☐ Do you think you get enough sleep at night? Number of hours of sleep per night _____
- ☐ Does pain wake you from sleep?
- ☐ Does pain make it hard for you to fall asleep?

Does your bed partner complain of:

- ☐ Your loud snoring?
- ☐ Your partner sometimes sleeps in another room at night because of your snoring?
- ☐ Your twitching legs, kicking or excessive moving at night?
- ☐ Long breathing pauses during your sleep?

Do you have or ever had the following:

- ☐ Jaw popping, clicking or grinding?
- ☐ Your jaw ever locked or gotten stuck?
- ☐ Been diagnosed with TMJ?
- ☐ Been told you grind your teeth at night (brux)?
- ☐ Ever had a mouth guard made by a Dentist?
- ☐ Pain with chewing?

Rank how likely it would be for you to become drowsy during the day in the following situations:

0= Would never doze
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Epworth Sleepiness Scale

Situation	**Chance of dozing**
Sitting & Reading	
Watching TV	
Sitting inactive in a public place (i.e. theater)	
As a car passenger for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, stopped for a few minutes in traffic	
Total score:	

My sleep problems are:

Sleep Medications taken in the last year: (includes nonprescription)

☐ Do you have high blood pressure?
☐ Do you have any heart problems?
☐ Do you have type 2 diabetes or any other blood sugar problems?
☐ Do you have acid reflux or wake with heartburn at night or In the morning?
☐ Do you feel as though you are over your healthy weight?

What is your Ht: _____Ft. _____in. Wt: _____lbs.

Have you ever had a sleep study? ☐ Yes ☐ No

If YES, then please have the sleep lab fax results to: 281-296-6887. Thank you.

Chief Concern (if pain, use level 0-10): _____

Associated Symptoms and Pain Level (0-10):

- ☐ Fullness in the ears/sinus _____
- ☐ Change in hearing _____
- ☐ Ring/Buzz in ears _____
- ☐ Ear pain _____
- ☐ Facial pain _____
- ☐ Headaches _____
- ☐ Migraine _____
- ☐ Morning headaches _____
- ☐ Electrical type pain _____
- ☐ Shoulder pain _____
- ☐ Upper backaches _____
- ☐ Low backaches _____
- ☐ Eye pain _____
- ☐ Neck-aches _____
- ☐ Difficulty Swallowing _____
- ☐ Numbness _____
- ☐ Tooth loss
- ☐ Bite is off
- ☐ Tooth pain/sensitivity _____
- ☐ Grinding
- ☐ Clenching
- ☐ Broken teeth
- ☐ Jaw pain _____
- ☐ Clicking of jaw
- ☐ Rt TMJ pain _____
- ☐ Lt TMJ pain _____
- ☐ Episodes of locking closed
- ☐ Episodes of locking open
- ☐ Jaw locked now
- ☐ Pain while eating _____
- ☐ Difficulty open/close Mouth _____
- ☐ Morning locked jaw
- ☐ Dizziness
- ☐ Visual disturbances
- ☐ Insomnia/trouble sleeping
- ☐ Fatigue
- ☐ Other _____

Have you had a recent motor vehicle accident, a workers comp accident or any trauma to the head? ☐ Yes ☐ No

Current medications including over the counter, supplements and vitamins (if long list, put on separate sheet):

History of present illness:

Quality: _____ (Example: dull ache, sharp, throbbing, pressure, etc.)

Duration: _____ (How long does the pain last?)

Severity: _____ (How severe is the pain/problem on a scale of 1-10 with 10 the most severe?)

Context: _____ (Where were you or what were you doing at the onset of this pain/problem? Eating, etc)

Timing: _____ (Is the pain/problem intermittent, constant, AM, PM, etc.?)

Modifying factors: _____ (What makes the pain/problem worse or better? Chewing, opening Jaw? Hot, cold? Talking?)

Associated signs/symptoms: _____ (Any other symptoms not mentioned above?)

Any prescription medications or over the counter medications taken In the last year for this condition

Patient social history:

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily, how much? _____

Use of tobacco: ☐ Never ☐ Previously, but quit: _____ Current packs/ day: _____

Use of drugs: ☐ Never Type/Frequency _____

Exercise how often? ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Type of exercise? _____

Do you consider yourself a religious/spiritual person? ☐ Yes ☐ No Do you have thoughts of suicide? ☐ Yes ☐ No

Any Oral habits? (Nail biting, gum chewing, etc.) _____

Do you feel you have adequate social support? ☐ Yes ☐ No

Review of Systems: Please mark all that apply past or present (many of these concerns may have a direct effect on your problem)

♦ GENERAL MEDICAL
- ☐ Good general health lately
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ Drug Rehab / Detox

♦ RESPIRATORY
- ☐ Chronic or frequent coughs
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ COPD
- ☐ Tuberculosis

♦ MUSCULOSKELETAL (NOT TMJ)
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Weakness of muscles or joints
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Osteoarthritis
- ☐ Osteopenia / Osteoporosis
- ☐ Artificial joints _____

♦ HEMATOLOGIC/LYMPHATIC
- ☐ Slow to heal after cuts
- ☐ Bleeding or bruising tendency
- ☐ Anemia
- ☐ Phlebitis
- ☐ Hemophilia
- ☐ Other bleeding disorder _____
- ☐ Past transfusion
- ☐ Sickle cell disease/trait
- ☐ Enlarged glands

♦ EYES
- ☐ Eye disease or injury
- ☐ Wear Glasses/contact lenses
- ☐ Blurred or double vision

♦ EARS/NOSE MOUTH/THROAT
- ☐ Hearing loss
- ☐ Ear ringing
- ☐ Earaches or drainage
- ☐ Chronic sinus problem
- ☐ Nose Bleeding
- ☐ Mouth Sores
- ☐ Gum Bleeding
- ☐ Bad breath or bad taste
- ☐ Sore throat
- ☐ voice change
- ☐ Swollen glands in neck

♦ GASTROINTESTINAL
- ☐ Loss of appetite
- ☐ Change in bowel movements
- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Painful bowel movements
- ☐ Constipation
- ☐ Rectal bleeding/ blood in stool
- ☐ Abdominal pain
- ☐ Crohn's disease
- ☐ Celiac Disease
- ☐ IBS
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Ulcers
- ☐ Gastritis

♦ INTEGUMENTARY (SKIN, BREAST)
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Varicose veins
- ☐ Breast pain
- ☐ Breast lump

♦ NEUROLOGICAL
- ☐ Frequent or recurring headaches
- ☐ Light headed or dizzy
- ☐ Convulsions or seizures
- ☐ Numbness or tingling sensations
- ☐ Tremors
- ☐ Paralysis
- ☐ Head injury
- ☐ Migraines

♦ ALLERGIC/IMMUNOLOGIC
- ☐ Environment allergies
- ☐ History of skin reaction or other adverse reaction to:
  - ☐ Penicillin or other antibiotics
  - ☐ Opioids / Narcotics
  - ☐ Novocaine / Local anesthesia
  - ☐ Anti-inflamatories
  - ☐ Tetanus antitoxin or other serum
  - ☐ Iodine, Merthiolate or other antiseptic
  - ☐ Latex
  - ☐ Other drugs/medications

    _____

    _____
  - ☐ Known food allergies

    _____

    _____

♦ CARDIOVASCULAR
- ☐ Heart disease
- ☐ Heart Attack
- ☐ High blood pressure
- ☐ Heart palpitation
- ☐ Heart murmur/MVP
- ☐ Swelling
- ☐ Chest pain or angina
- ☐ Stroke/TIA
- ☐ Pacemaker
- ☐ Coronary Stent
- ☐ Artificial Heart Valve

♦ GENITOURINARY
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Kidney disease
- ☐ Testicle pain
- ☐ Pain with periods
- ☐ Irregular periods
- ☐ Pelvic Floor Pain
- ☐ Female - # of pregnancies

♦ PSYCHIATRIC
- ☐ Memory loss or confusion
- ☐ Anxious/Nervous
- ☐ Depression
- ☐ PTSD
- ☐ Seeing psychologist / Therapist

♦ ENDOCRINE
- ☐ Glandular or hormone problem
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Heat or cold Intolerance
- ☐ Skin becoming dryer
- ☐ Diabetes Type 1 or Type 2
- ☐ Hypothyroidism
- ☐ Hashimoto's Thyroiditis
- ☐ Hyperthyroidism

♦ OTHER HEALTH CONDITIONS
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ POTS
- ☐ MCAS
- ☐ Ehlers-Danlos Syndrome
- ☐ Dysautonomia
- ☐ Autism
- ☐ Sleep Apnea
- ☐ Acid Reflux

Previous Hospitalizations and Surgeries	When?	Hospital, City, State

Dental History;

Date of last dental visit: _____ What was done? _____

Do you have any dental problems now? _____

What have been the character of your dental treatments in the past:

☐ Fillings ☐ Gum Disease ☐ Orthodontics When? _____

☐ Broken Teeth ☐ Bite adjustment ☐ Oral Surgery When? _____

Have you ever had your teeth ground or bite adjusted? ☐ Yes ☐ No

Are any of your teeth sensitive to temperature or to chewing? ☐ Yes ☐ No

Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

I understand the questions above and have answered them truthfully.
I certify that I am the patient or legal agent for the patient.

Patient/Parent Signature: _____ Date: _____

Facial Pain Screening History

Name: _____ Age: _____ Date: _____

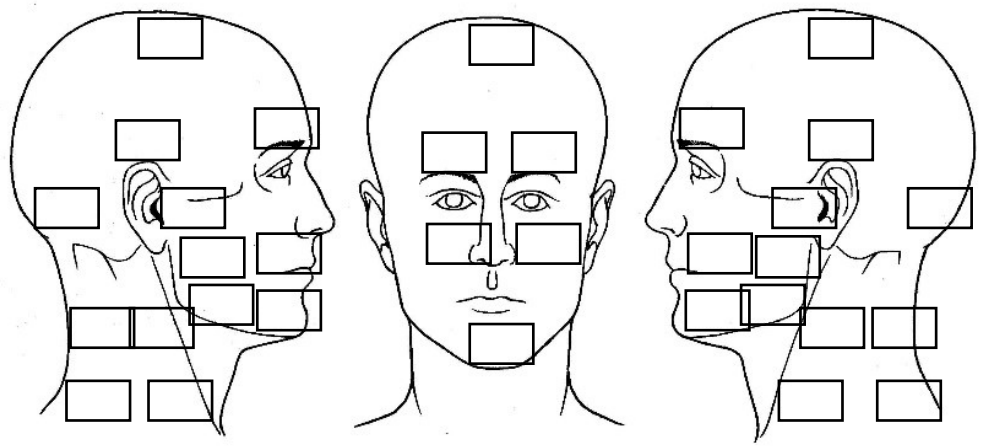
Have you seen a healthcare provider for this condition? ☐ Yes ☐ No

Treatment Done: _____ Imaging Done: _____

If treatment was done, did any make you feel better? ☐ Yes ☐ No

Did any make you feel worse? ☐ Yes ☐ No

On the figures below, please *outline location of your pain:* Where 1=*(Little pain) and* 10=*(Worst pain Imaginable)*



Mark Intensity of pain in appropriate areas:

Right **Front** **Left**

TM Joint Dysfunction?

Does your jaw pop or click when you open? ☐ Yes ☐ No With Pain? ☐ Yes ☐ No

Which side pops/clicks? ☐ L ☐ R Which side has pain with popping? ☐ L ☐ R

If your Jaw has locked when did this first happen?

Is the locking (circle one) Daily/ Episodic? ☐ Daily ☐ Episodic

Does your jaw ever get "stuck"? ☐ Yes ☐ No When does this happen? _____

Do you have neck pain? ☐ Yes ☐ No

If You Have Headaches?

"Normal Headaches": Location: _____ Intensity: _____(0-10) How often? _____

☐ Visual effects ☐ Light sensitivity ☐ Sound Sensitivity ☐ Dizziness ☐ Nausea ☐ Neck

What medications do you take for these headaches? _____

"Severe Headaches": Location: _____ Intensity: _____(0-10) How often? _____

☐ Visual effects ☐ Light sensitivity ☐ Sound Sensitivity ☐ Dizziness ☐ Nausea ☐ Neck

☐ Severe headaches progress from the normal headache.

☐ Severe headaches come out of nowhere

What medications do you take for these headaches? _____

Does anyone in your family get migraines? ☐ Yes ☐ No If yes, who? _____

Are you depressed?	☐ Often	☐ Sometimes	☐ Never
Do you consider yourself?	☐ Calm (laid back)	☐ Moderate	☐ Tense (uptight)
Do you have stress in your life?	☐ None	☐ Some	☐ Enormous
Do you have thoughts of suicide?	☐ Never	☐ Sometimes	☐ Often

What percent of your pain relief do you expect with treatment? _____

For you, is this condition (pick one) ☐ Long term ☐ Recent How Long _____

Do you sleep in the same room with someone who snores? ☐ Yes ☐ No

If 'Yes' does this disturb your sleep? ☐ Yes ☐ No

What Does Your Pain Feel Like?

Some of the words below describe your **present** pain. Tick **Only** those words that describe It. Leave out any category that is not suitable.

1	☐ Flickering	2	☐ Jumping	3	☐ Pricking	4	☐ Sharp	5	☐ Pinching
	☐ Quivering		☐ Flashing		☐ Boring		☐ Cutting		☐ Pressing
	☐ Pulsing		☐ Shooting		☐ Drilling		☐ Lacerating		☐ Gnawing
	☐ Throbbing				☐ Stabbing				☐ Cramping
	☐ Beating				☐ Lancinating				☐ Crushing
	☐ Pounding								
6	☐ Tugging	7	☐ Hot	8	☐ Tingling	9	☐ Dull	10	☐ Tender
	☐ Pulling		☐ Burning		☐ Itchy		☐ Sore		☐ Taut
	☐ Wrenching		☐ Scalding		☐ Smarting		☐ Hurting		☐ Rasping
			☐ Searing		☐ Stinging		☐ Aching		☐ Splitting
							☐ Heavy		
11	☐ Tiring	12	☐ Sickening	13	☐ Fearful	14	☐ Punishing	15	☐ Wretched
	☐ Exhausting		☐ Suffocating		☐ Frightful		☐ Grueling)		☐ Blinding
					☐ Terrifying		☐ Cruel		
							☐ Vicious		
							☐ Killing		
16	☐ Annoying	17	☐ Spreading	18	☐ Tight	19	☐ Cool	20	☐ Nagging
	☐ Troublesome		☐ Radiating		☐ Numb		☐ Cold		☐ Nauseating
	☐ Miserable		☐ Penetrating		☐ Drawing		☐ Freezing		☐ Agonizing
	☐ Intense		☐ Piercing		☐ Squeezing				☐ Dreadful
	☐ Unbearable				☐ Tearing				☐ Torturing

I understand the questions above and have answered them truthfully. I certify that I am the patient or legal agent for the patient

Patient/Parent Signature: _____ Date: _____

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