



HEALTHY SMILES. BEAUTIFUL FACES.

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1. Name: _____ Birthday: _____
First MI Last

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (_____) _____ Age: _____ Sex: _____ Referring doctor: _____

2. In your own words, describe why you are here: _____

3. Are you presently under the care of a physician or have you been in the past year? Yes No

Physician's name: _____

Condition treated: _____

Treatment: _____

Name any medication you are taking: _____

4. Dentist's name: _____

Date of last dental appointment: _____

Treatment prescribed: _____

5. Do you have any problems with your jaw? Yes No

If yes, please describe: _____

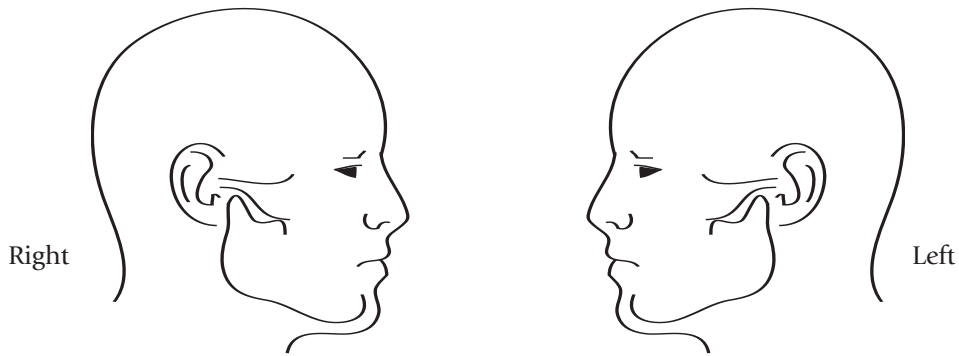
How long have you had these problems? _____

6. Have you received treatment for jaw problems? Yes No

Who directed this treatment? _____

What was the treatment? (indicate below)	Yes	No	Results:	Good	Fair	Poor
Bite splint	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occlusal adjustment	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontics	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. On the figure below, mark an X where you have pain and circle the X where pain is most severe.



When do you have this pain? _____

8. Do you do anything now to relieve your pain? Yes No

If yes, what? _____

9. Are you aware of anything that makes your pain worse? Yes No

If yes, what? _____

10. Do your jaw joints make noises? Yes No

Right jaw Clicking Popping Grinding Other _____

Left jaw Clicking Popping Grinding Other _____

11. Has your jaw ever locked open? Yes No

If yes, when did this first occur? _____

How often has this occurred? _____

12. Has your jaw ever locked closed or partly closed? Yes No

If yes, when did this first occur? _____

How often has this occurred? _____

13. Have you ever injured your jaws? Yes No

If yes, when? _____

Please describe the injury: _____

14. Do you consider yourself to be under more stress than most people? Yes No

15. Please provide any additional information you feel may be helpful in the diagnosis or treatment of your condition:
