PATIENT INFORMATION FORM DATE_____

PATIENT INFORMATION

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

Address:_____
(Street) (Apt. #)

_____
(City) (State) (ZIP)

Birth Date:_____ **Email Address of Parent:**_____

Employer/School:_____ **Occupation/Grade:**_____

Home Phone:(____)_____ **Work Phone:**(____)_____

Cell Phone:(____)_____

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

Dentist's Name_____**Dentist's Phone:**(____)_____
(First) (Last)

NOTE: *If you would like us to accurately determine your orthodontic benefits and subsequently bill your insurance as a courtesy for any future treatment, insurance information must be* ***filled out completely*** *at the time of your initial examination.*

Do you have orthodontic insurance? No____ Yes____ Carrier:_____**Phone #:**_____

Name of Primary Insured:_____ **Primary's Employer:**_____

Primary's Birth Date:_____ **Primary's Social Security #:**_____ **Group/Plan No:**_____

RESPONSIBLE PARTY INFORMATION

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

Address:_____
(Street) (Apt. #)

_____
(City) (State) (ZIP)

Previous Address (if less than 3 years):_____

Relationship to Patient:_____

Employer:_____ **Occupation:**_____ **No. of Years Employed:**_____

Home Phone:(____)_____ **Work Phone:**(____)_____

Spouse's Name:_____ **Spouse's Employer:**_____

Spouse's Occupation:_____ **Spouse's Work Phone:**(____)_____

If Patient is a minor parents are: ___Married ___Divorced ___Separated ___Single ___Remarried ___Widowed

EMERGENCY INFORMATION

Name of Nearest Relative Not Living With You:_____
(Last) (First)

Address:_____
(Street) (Apt. #)

_____(___)_____
(City) (State) (ZIP) Phone Relationship

ELLIOTT ORTHODONTICS

Smiles from the Heart

TMJ QUESTIONNAIRE

Name: _____
Date: _____
Primary Care Physician Name and Phone #: _____

Primary Care Physician Email:_____

I. MEDICAL/ DENTAL HISTORY

A. General Health:

	Good	Fair	Poor
1. Physical……....	☐	☐	☐
2. Emotional……..	☐	☐	☐

	Yes	No
B. Do you have a personal physician?.....	☐	☐
C. Are you currently under the care of a physician?.....	☐	☐
D. Have you ever been seriously ill?.....	☐	☐
E. Have you been hospitalized in the past 5 years?.....	☐	☐
F. Have you ever had a major operation?.....	☐	☐
G. Women: Are you pregnant?.....	☐	☐
H. Has there been any change in your general health in the last year?.....	☐	☐
I. Has there been a major weight loss, without dieting, in recent months?.....	☐	☐
J. Worried about receiving medical/ dental treatment?.....	☐	☐
K. Have you now, or in the past, experienced any of the following medical conditions:.....	☐	☐

☐ Allergies
☐ Addiction
☐ Anemia (low blood cell count)
☐ Arthritis
☐ Asthma
☐ Arteriosclerosis
☐ Bleeding Problems
☐ Blood Diseases
☐ Blood Pressure – high
☐ Blood Pressure – low
☐ Blood Transfusions
☐ Bone Disorder
☐ Breathing or Lung Disorder
☐ Cancer
☐ Chronic pain condition
☐ Diabetes
☐ Dizziness
☐ Drug/substance abuse
☐ Epilepsy
☐ Endocrine problems
☐ Female problems
☐ Fibromyalgia
☐ Gastrointestinal (GI) problems (ulcers)
☐ Genitourinary problems
☐ GERD (Acid Reflux)
☐ Heart Disease
☐ Hearing disorder, ringing ears
☐ Hepatitis
☐ HIV/AIDS/ARC (circle)
☐ Jaundice
☐ Kidney Disease
☐ Latex allergy
☐ Migraine headaches
☐ Musculo-skeletal disorder
☐ Neurological disorder
☐ Psychiatric disorder
☐ Rheumatic fever
☐ Sleep disturbance (snoring, night gasping)
☐ Stroke
☐ Venereal Disease
☐ OTHER_____

L. Medications currently taken by the patient?
☐ None
☐ Antibiotics

☐ Birth control pills/hormones
☐ Bisphosphonates (Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, and Zometa, etc.)
☐ Diet Pills (diuretics)
☐ Heart Pills (digitalis, etc.)
☐ Insulin
☐ Muscle Relaxants (valium, etc.)
☐ Pain Pills (Demerol, codeine, etc.)
☐ Sleeping pills (barbiturates)
☐ Tranquilizers or Antidepressants (valium, etc.)
☐ OTHER_____

M. Allergies to medical and/or food:

☐ None
☐ Antibiotics
☐ Dairy Products
☐ Dental anesthetics
☐ Dyes in foods
☐ Metals
☐ Pain pills
☐ Wheat, cereals, gluten
☐ OTHER_____

II. CRANIOFACIAL SYMPTOMS OF THE HEAD, NECK AND FACE

Fill in the appropriate response square indicating whether or not you currently have, or previously had, the following conditions or symptoms, and identify which side, right side R of L where appropriate: of both sides are involved, mark right and left sides.

Current Condition

	Yes	No
1. Bleeding gums and/or gum disease?	☐	☐
2. Crowns on teeth and/or caps?	☐	☐
3. Do you chew gum regularly?	☐	☐
4. Do you feel that your bite closed?	☐	☐
5. Do you feel that there is not enough room for your tongue?	☐	☐
6. Missing back teeth with no replacement?	☐	☐
7. Oral Surgery?	☐	☐
8. Orthodontic treatment?	☐	☐
9. Periodontal disease (pyrrohea)?	☐	☐
10. Sore or painful teeth?	☐	☐
11. Teeth sensitive to cold and/or hot?	☐	☐
12. Teeth badly worn?	☐	☐
13. Teeth have been ground by dentist?	☐	☐
14. Teeth feel very loose?	☐	☐
15. Teeth extracted within the past three years?	☐	☐
16. TMJ (jaw joint) treatment?	☐	☐
17. Treated for a bad bite?	☐	☐
18. Wisdom teeth removed?	☐	☐
19. Do you have frequent canker sores or cold sores?	☐	☐

A. CRANIOFACIAL PAIN	Yes	No
20. Do you have generalized facial pain?	☐	☐
21. On which side is there constant or recurring pain? Which Side?_____	☐	☐
22. Does the pain or discomfort disturb you sleep?	☐	☐
23. Would you describe the pain as a dull, aching sensation?	☐	☐
24. Would you describe the pain as stabbing, sharp, severe sensation?	☐	☐
25. Do you suffer from chronic headache?	☐	☐
26. Do you ever have migraine headaches?	☐	☐
27. Do you have tension headaches?	☐	☐
28. Headaches in the temples?	☐	☐
29. Headaches in the back of the head?	☐	☐
30. Are there times when you notice that the pain or problems are less or gone completely?	☐	☐
31. Do you have pain in teeth on awakening?	☐	☐
32. Do your teeth hurt from clenching or chewing?	☐	☐
33. Does your jaw ache when you chew?	☐	☐
34. Does your jaw hurt when you open wide or take a big bite?	☐	☐
35. Does it now hurt to open wide?	☐	☐
36. Do you have ear pain?	☐	☐
37. Do you have pain in front of the ears?	☐	☐
38. Is the degree of pain same in morning as evenings?	☐	☐

	Yes	No
39. Do you have chronic stiff neck?	☐	☐
40. Do you have neckaches (neck pain)?	☐	☐
41. Have you ever had chronic shoulder or back pain?	☐	☐

42. When are your symptoms worse:
- ☐ Upon rising in the morning?
- ☐ At work?
- ☐ At the end of the workday?
- ☐ At home?
- ☐ At school?

	Yes	No
43. Have you ever been treated for pain?	☐	☐
44. Have you ever had injections or nerve blocks for pain?	☐	☐
45. Did any of the injections bring relief from pain?	☐	☐
46. Have you ever been operated on to relieve pain?	☐	☐
47. Did the operation bring relief from pain?	☐	☐

48. How often do you take medicine for the relief of pain?
- ☐ Never
- ☐ Seldom (a few times a year)
- ☐ Occasionally (once a month)
- ☐ Often (weekly)
- ☐ Frequently (daily)

B. BREATHING PROBLEMS	Yes	No
49. Allergies?	☐	☐
50. Does your nose feel stuffy when you don't have a cold?	☐	☐
51. Does your nose run when you		

don't have a cold? ☐ ☐
52. Sinus problems? ☐ ☐
53. Do you snore? ☐ ☐
54. Mouth breather? ☐ ☐
55. Do you have sleep apnea? ☐ ☐

C. EYE PROBLEMS **Yes** **No**

56. Pain in, around, or behind eyes? ☐ ☐
57. Eyesight blurs? ☐ ☐
58. Eyelid tics (twitches)? ☐ ☐
59. Eyes blink excessively? ☐ ☐
60. Do your eyes water most of the time (tearing)? ☐ ☐

D. EAR PROBLEMS **Yes** **No**

61. Earaches or ear pain? ☐ ☐
62. Hearing loss? ☐ ☐
63. Grating noise in ears (like sand particles)? ☐ ☐

Yes **No**

64. Itchiness in ears? ☐ ☐
65. Stuffiness in ears? ☐
66. Ringing, hissing, or buzzing sounds in ears? ☐ ☐
67. Whooshing or throbbing sound in ears? ☐ ☐

E. EQUILIBRIUM PROBLEMS **Yes** **No**

68. Do you feel lightheaded or dizzy? ☐ ☐
69. Often feel like vomiting or nauseated? ☐ ☐

F. POSTURE PROBLEMS **Yes** **No**

70. Do you have backaches? ☐ ☐
71. Do you have an abnormal curvature of the spine? ☐ ☐
72. Are your legs of unequal lengths? ☐ ☐
73. Do you have problems sitting still for prolonged time? ☐ ☐
74. Do you cradle the phone between your head and shoulders? ☐ ☐
75. Does your work involve typing/ word processing? ☐ ☐
76. Do you wear high heels
    - ☐ Seldom
    - ☐ Occasionally
    - ☐ Frequently

G. LIFESTYLE PROBLEMS **Yes** **No**

77. Are you under a lot of stress? ☐ ☐
78. Do you bite your nails, tongue, or lips? ☐ ☐
79. Take any mood affecting drugs or stimulants? ☐ ☐
80. Do you exercise regularly? ☐ ☐
81. Do you usually eat breakfast? ☐ ☐
82. Do you work more than 40 hours a week? ☐ ☐
83. Do you overeat? ☐ ☐

H. JAW (TMJ) SYMPTOMS **Yes** **No**

84. Have you ever been treated for jaw joint problems, or facial muscle spasms? ☐ ☐
85. Do you have difficulty in chewing your food? ☐ ☐
86. Do you grind your teeth during the night? ☐ ☐
87. Has anyone told you that you grind your teeth? ☐ ☐
88. Are you aware of clenching your teeth during the day? ☐ ☐
89. Are you aware of clenching your teeth during the night? ☐ ☐
90. Are there times when you can't open your mouth widely? ☐ ☐
91. Do you have difficulty in opening your mouth widely? ☐ ☐
92. Does it hurt to open your mouth widely? ☐ ☐

Yes **No**

93. Does your mouth go to one side when fully opened? ☐ ☐
94. Has your jaw ever locked or were you unable to open or close you mouth? ☐ ☐
95. Have you had pain in your jaw joint? ☐ ☐
96. Do you hear sounds in your jaw joint? ☐ ☐
97. Do you hear grating sounds in your jaw joint? ☐ ☐
98. Do you hear or feel a clicking or popping in your jaw joint? ☐ ☐
99. Does your jaw make clicking or popping sounds when you chew? ☐ ☐
100. Does your jaw feel tired after a big meal? ☐ ☐
101. Have you experienced numbness of shoulders, arms, hands, or fingers? ☐ ☐
102. Do you have pain in your neck and/or shoulders? ☐ ☐

I. TRAUMA RELATED PROBLEMS **Yes** **No**

103. Accident or trauma to face? ☐ ☐
104. Accident or trauma to jaw? ☐ ☐
105. Accident or trauma to head? ☐ ☐
106. Have you ever received a severe blow to the side of the head or jaw? ☐ ☐
107. Accident or trauma to neck? ☐ ☐
108. Whiplash or neck injury? ☐ ☐
109. Have you worn a cervical traction neck collar? ☐ ☐
110. Has there been a strain or stretching of the jaw while yawning, chewing, or opening the mouth wide? ☐ ☐
111. Have you experienced a fall within the last two years? ☐ ☐

J. Are there any other significant medical or dental problems?

	Yes	No
_____	☐	☐

_____

_____

(Please Explain)

III. PRACTITIONERS

Please indicate which practitioners you have seen since your pain began for treatment and relief of pain.

	Have Seen	Now Seeing
1. Acupuncturists	☐	☐
2. Allergist	☐	☐
3. Anesthesiologist	☐	☐
4. Asian Medicine	☐	☐
5. Cardiologist (heart)	☐	☐
6. Chiropractor	☐	☐
7. Spiritual Counselor	☐	☐
8. Dentist	☐	☐
9. Dermatologist (skin)	☐	☐
10. Dietician	☐	☐
11. E.N.T.	☐	☐
12. Endocrinologist	☐	☐
13. Faith Healer	☐	☐
	Have Seen	**Now Seeing**
14. Family Physician	☐	☐
15. Gynecologist/Obstetrician	☐	☐
16. Hypnotist	☐	☐
17. Internist	☐	☐
18. Massage Therapist	☐	☐
19. Naturopath	☐	☐
20. Neurologist	☐	☐
21. Neurosurgeon	☐	☐
22. Nutritionist	☐	☐
23. Ophthalmologist (eyes)	☐	☐
24. Optometrist	☐	☐
25. Orthopedist (bones, joints)	☐	☐
26. Orthodontist	☐	☐
27. Osteopathic physician	☐	☐
28. Pediatrician (children)	☐	☐
29. Physical therapist	☐	☐
30. Physiatrist	☐	☐
31. Plastic Surgeon	☐	☐
32. Proctologist	☐	☐
33. Psychiatrist	☐	☐
34. Psychologist	☐	☐
35. Radiologist	☐	☐
36. Rheumatologist	☐	☐
37. Surgeon	☐	☐
38. Other 1	☐	☐
39. Other 2	☐	☐

IV. PAIN SUMMARY

Please identify your areas of pain indicating right R and/or left L that you presently or frequently experience.

1. Top of head	☐**R**	☐**L**
2. Back of head	☐**R**	☐**L**
3. Frontal headache	☐**R**	☐**L**
4. Eye and eyebrow	☐**R**	☐**L**
5. Temporal headache	☐**R**	☐**L**
6. Jaw and cheek	☐**R**	☐**L**
7. Ear and jaw joint area	☐**R**	☐**L**
8. Toothache	☐**R**	☐**L**
9. Front of neck and throat	☐**R**	☐**L**
10. Side of neck	☐**R**	☐**L**
11. Back of neck	☐**R**	☐**L**
12. Upper thoracic of back	☐**R**	☐**L**
13. Mid-thoracic of back	☐**R**	☐**L**
14. Lower back	☐**R**	☐**L**
15. Back of shoulder	☐**R**	☐**L**
16. Front of shoulder	☐**R**	☐**L**
17. Back of arm	☐**R**	☐**L**
18. Front of arm	☐**R**	☐**L**
19. Upper chest area	☐**R**	☐**L**

COMMENTS:

_____

_____

_____

_____

_____

_____

_____

To the best of my knowledge, all the preceding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in my health or medications that is not reported above, I will inform the doctor at my next visit.

_____

Patient/Responsible Party Signature

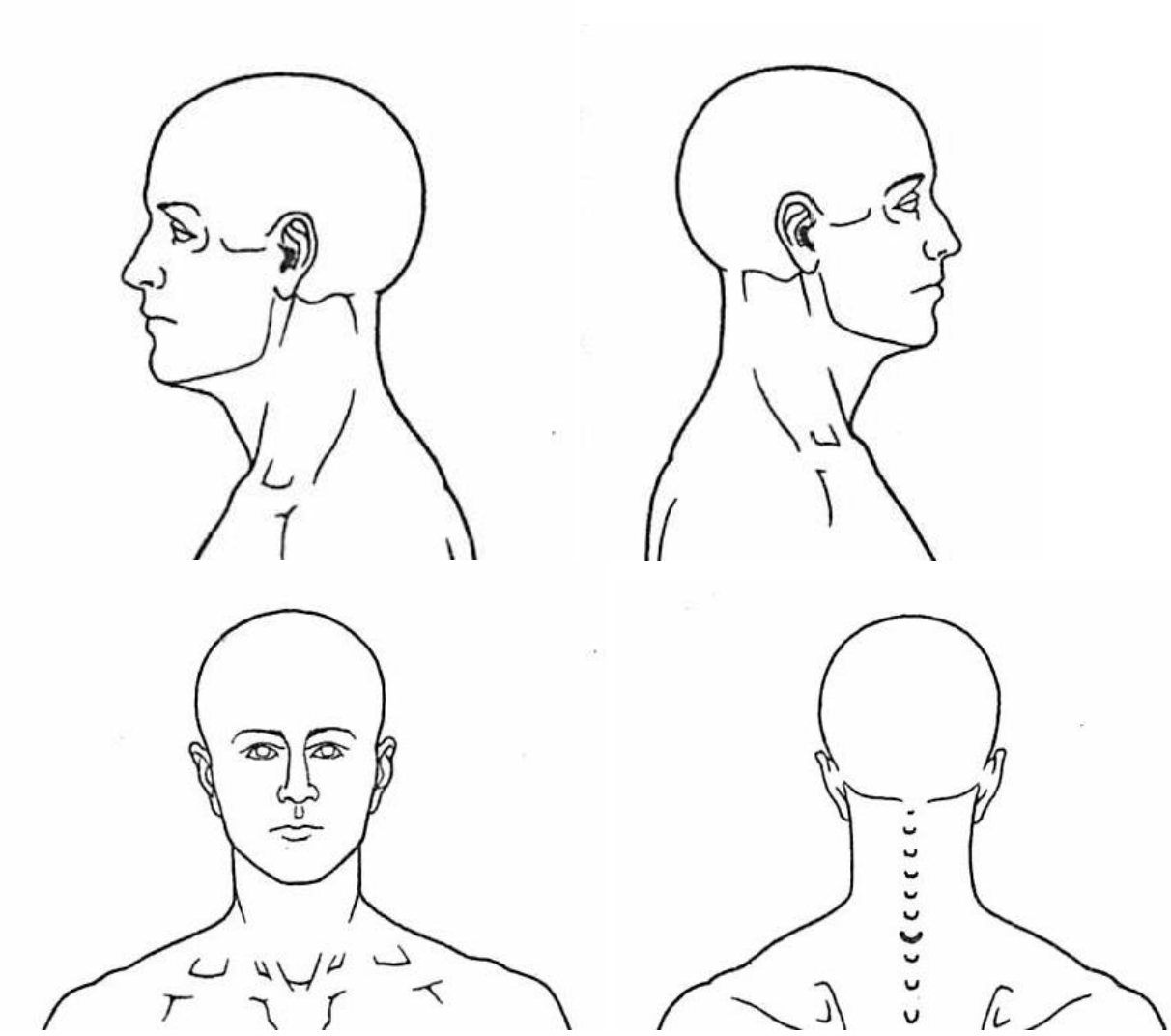
_____

Date

Name_____

Date_____

Draw painful areas in solid red and sensitive areas in multiple red dots.



Draw painful areas in solid red and sensitive areas in multiple red dots.