

	Yes	No
Are you currently taking any medication? What? _____	_____	_____
Are you allergic to any food or medicine? What? _____	_____	_____
Have you ever had orthodontic treatment?	_____	_____
Have you ever had periodontal disease?	_____	_____
Have you ever been treated for a "bad bite"?	_____	_____
Have you ever been treated for problems or discomfort with your jaw joint, or facial muscles?	_____	_____
Do you ever awaken with soreness of your teeth or jaws?	_____	_____
Do you clench or grind your teeth during the day?	_____	_____
Have you ever been told that you grind your teeth while sleeping?	_____	_____
Are your teeth sensitive when chewing?	_____	_____
Do you have tension or migraine headaches?	_____	_____
Do you frequently have neckaches or stiff neck muscles?	_____	_____
Do your jaw muscles become tired frequently?	_____	_____
Do you have difficulty in opening your mouth widely?	_____	_____
Do you have difficulty in swallowing?	_____	_____
Have you ever had arthritis?	_____	_____
Have you ever received a severe blow to the side of the head or jaw?	_____	_____
Have you ever had problems with your ears, such as ringing or change of hearing?	_____	_____
Do you ever hear clicking or popping sounds from your jaw joint?	_____	_____
Are you presently in any pain from your jaw joint or muscles?	_____	_____
Does pain or discomfort from your jaw joint interfere with your work or other activities?	_____	_____
Are there times when you notice that this problem or pain is less or gone completely?	_____	_____
Do you feel you need treatment for this problem?	_____	_____
Do you have a problem with insomnia?	_____	_____
Do you take aspirin frequently?	_____	_____
Is there any other information you feel we should know?	_____	_____
What is your chief concern? Please explain. _____ _____		

REFERRED TO THIS OFFICE BY: _____

I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE: _____ DATE: _____