



Orthopedic and TMJ Physical Therapy Center Confidential Health Questionnaire

Name: _____

D.O.B.: _____

Date: _____

Occupation: _____

JAW RELATED QUESTIONS

1. Does it hurt to chew? Yes No
2. Does it hurt to open wide? Yes No
3. Do you have headaches? Yes No
4. Is it difficult to swallow? Yes No
5. Are you teeth sensitive or sore? Yes No
6. Do you have implants or splints? Yes No
7. Do you have neck pain? Yes No
8. Do you have face pain Yes No
9. Is your pain constant? _____ Aching? _____ Burning? _____ Stabbing? _____ Other? _____
Worse in the morning? _____ Afternoon _____ Evening? _____ Night? _____
10. Do you have problems with your ears? _____ Hearing? _____ Dizziness? _____ Other? _____
11. Does your jaw make a popping noise? _____ Clicking? _____ Grinding? _____ Other? _____
12. Do you ever clench or grind your teeth? _____ During the day? _____ At night? _____
13. Has your jaw ever locked or slipped out of place? _____

GENERAL HEALTH QUESTIONS.

14. Have you ever had any of the following conditions or problems? Be descriptive when appropriate.

- | | | |
|--|---|---|
| <input type="radio"/> Anemia | <input type="radio"/> Hemophilia | <input type="radio"/> Renal Disease |
| <input type="radio"/> Arthritis | <input type="radio"/> Hemorrhoids | <input type="radio"/> Respiratory problems |
| <input type="radio"/> Asthma | <input type="radio"/> High/low blood pressure | <input type="radio"/> Seizures |
| <input type="radio"/> Cataracts | <input type="radio"/> HIV, AIDS | <input type="radio"/> Skin Sensitivities or Condition |
| <input type="radio"/> Cancer | <input type="radio"/> Irritable Bowel | <input type="radio"/> Thyroid problems |
| <input type="radio"/> Chest Pains | <input type="radio"/> Kidney/Bladder Stones | <input type="radio"/> Vascular Disease |
| <input type="radio"/> Circulatory problems | <input type="radio"/> Migraines | <input type="radio"/> Musculoskeletal |
| <input type="radio"/> Constipation/Impaction | <input type="radio"/> Mitral valve prolapse | <input type="radio"/> TMJ <input type="radio"/> Shoulders |
| <input type="radio"/> Convulsions | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Neck <input type="radio"/> Hips |
| <input type="radio"/> Diabetes | <input type="radio"/> Osteomyelitis | <input type="radio"/> Back <input type="radio"/> Knees |
| <input type="radio"/> Digestive problems | <input type="radio"/> Osteoporosis | <input type="radio"/> Feet |
| <input type="radio"/> Eliminatory problems | <input type="radio"/> Pacemaker | <input type="radio"/> Other |
| <input type="radio"/> Falls | <input type="radio"/> Parkinson's Disease | _____ |
| <input type="radio"/> Fractures | <input type="radio"/> Polyps | _____ |
| <input type="radio"/> Head Injuries | <input type="radio"/> Phlebitis | |
| <input type="radio"/> Heart condition | <input type="radio"/> Pregnancy Trauma | |

15. Hours of sitting per day (computer + driving) _____

16. When was your last Medical exam? Within last month Within last 6 months More than 6 mo.

17. Have you ever been diagnosed for cancer, a tumor, or noticed any lumps or swellings? Yes No

34. In your own words please describe your problem: _____
