PERSONAL HISTORY

Please provide us with the following information. Should you have any questions do not hesitate to contact a member of our staff.

1) Your date of birth — Day / Month / Year: ____ / ____ / ____

2) Your gender — Male ☐ Female ☐

If you are female have you born one or more children — Yes ☐ No ☐

3) What is your chief complaint?

☐

4) Have you suffered from any of the following disorders?

	Yes	No
Hypertension	☐	☐
Arthritis	☐	☐
Gout	☐	☐
Muscle dysfunction	☐	☐

Other (please specify):

____

____

5) Are you taking any medications? Yes ☐ No ☐

If yes, please list them: ______________________________

6) Are you currently under the care of a physician? Yes ☐ No ☐

If yes, please provide us with his/her contact information: ______________________________

____

7) Have you ever experienced any traumatic injury to your head, jaw, neck or back?

Yes ☐ No ☐

If yes please describe the accident: ____________________

____

8) Do your suffer from headaches? Yes ☐ No ☐

If yes, please answer the following:

Frequency - Once or twice a day ☐ Many times a day ☐

Almost constantly ☐ Only when I eat ☐

Duration - Many hours ☐ An hour or so ☐ Only a few minutes ☐

Severity - Mild ☐ Moderate ☐

Severe ☐ Acute to the point that I cannot function ☐

9) Do you smoke or use other forms of tobacco?

Yes ☐ No ☐

10) Do you drink coffee, tea or other drinks containing caffeine?

Yes ☐ No ☐

If yes, please specify: ____________________

11) Does you jaw joint make any noise when you open or close your mouth, or when you eat?

Yes ☐ No ☐

12) Does your jaw hurt when you open, close or eat?

Yes ☐ No ☐

13) Is there any other information that you feel we need to know?

Yes ☐ No ☐

If yes, please specify:____________________

____

Thank you for taking the time to provide us with this information.