

PATIENT QUESTIONNAIRE

SUBURBAN TMJ & SLEEP CENTER

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PATIENT INFORMATION

Preferred Name:

Today's Date:

Full Legal Name:

Date of Birth:

Address:

City/State/ZIP:

Cell Phone:

Home/Work Phone:

Email:

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed

Emergency Contact / Phone:

HOW CAN WE HELP YOU?

Please tell us what brings you in today?

What is your main concern?

What are your goals for treatment/quality of life?

PRIMARY CONCERNS

☐ Jaw pain

☐ Face pain

☐ Ear pain

☐ Headaches / migraines

☐ Jaw clicking / popping

☐ Jaw locking

☐ Limited opening

☐ Pain with chewing

☐ Clenching / grinding

☐ Sleep / snoring concerns

☐ Neck / shoulder pain

☐ Other:

PAIN TODAY

Are you having pain or discomfort?

☐ Yes

☐ No

Pain level (0–10):

When did it begin?

Patient Name:

Signature:

Date:

HEALTHCARE & TREATMENT HISTORY

REFERRING PROVIDER

Referred by:

Type: ☐ DDS ☐ MD ☐ ENT ☐ DC ☐ Other

Reason for referral:

HEALTHCARE PROVIDERS

Family Dentist:	Address

Family Physician:	
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Other/Specialist	
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☐ I authorize the Center to communicate with the healthcare providers listed above regarding my treatment.

Signature: Date:

PREVIOUS TREATMENT FOR THIS PROBLEM

List prior treatments, appliances, therapy, medication, injections, imaging or procedures related to your current concern.

Treatment/Medication	Provider	Approx Date

HISTORY OF YOUR CURRENT CONDITION:

When did the condition first occur?

What makes it worse?

What makes it better?

POSSIBLE CAUSE / TRIGGER

☐ Motorcycle accident	☐ Motor vehicle accident	☐ Work-related incident
☐ Athletic activity	☐ Fall	☐ Fight
☐ Illness	☐ Injury	☐ Other:

TMJ, HEADACHE & RELATED SYMPTOMS

HEADACHE / HEAD PAIN

Location	Side	Frequency
Front / forehead	☐ L ☐ R ☐ Both	☐ Monthly ☐ Weekly ☐ Daily
Temples	☐ L ☐ R ☐ Both	☐ Monthly ☐ Weekly ☐ Daily
Top of head	☐ L ☐ R ☐ Both	☐ Monthly ☐ Weekly ☐ Daily
Back of head	☐ L ☐ R ☐ Both	☐ Monthly ☐ Weekly ☐ Daily
Entire head	☐ L ☐ R ☐ Both	☐ Monthly ☐ Weekly ☐ Daily
Other:	☐ L ☐ R ☐ Both	☐ Monthly ☐ Weekly ☐ Daily

JAW SYMPTOMS

Jaw pain when opening	☐ L ☐ R ☐ Both	☐ Teeth grinding/clenching
Jaw pain at rest	☐ L ☐ R ☐ Both	☐ Limited Mouth opening
Jaw clicking/popping	☐ L ☐ R ☐ Both	☐ Jaw pain while chewing
Jaw locks open/closed (circle one)	☐ L ☐ R ☐ Both	

EAR, MOUTH, NOSE & EYE SYMPTOMS

☐ Tinnitus / ringing	☐ Ear pain	☐ Ear congestion
☐ Hearing loss	☐ Pain behind ear	☐ Recurrent ear infections
☐ Dry mouth	☐ Chronic sinusitis	☐ Burning tongue
☐ Cheek biting	☐ Snoring	☐ Blurred vision
☐ Double vision	☐ Eye pain / pressure	☐ Light sensitivity

NECK, SHOULDER & BACK SYMPTOMS

☐ Neck pain	☐ Limited neck movement	☐ Neck stiffness
☐ Shoulder pain / stiffness	☐ Swollen neck / glands	☐ Difficulty swallowing
☐ Tingling/numbness in hand or fingers	☐ Upper/middle/lower back pain	☐ Sciatica
☐ Scoliosis	☐ Other:	

PAIN DETAILS

Where is your pain?	Pain intensity (0–10):
Pain quality: ☐ Burning ☐ Dull ☐ Numbness ☐ Pressure ☐ Sharp ☐ Tingling	How often does it occur?
☐ Radiating	
How long does it last?	

ANYTHING ELSE WE SHOULD KNOW?

Patient Signature:	Date:
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WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT

Please rate your intensity 0 is NO PAIN, 10 IS MOST SEVERE

Ear Pain	
Headaches	
Limited ROM	
Pain when chewing	
Jaw Joint Noises	
Jaw Pain	
Migraine Headaches	
Muscle Twitching	
Locking Open/Closed (Circle one)	

MEDICAL HISTORY

ALLERGIES & CURRENT MEDICATIONS

Medication / substance allergies or reactions: ☐ None known ☐ Anesthetics ☐ Iodine ☐ Latex ☐ Metals

Other:

Medication	Dosage	Reason for Taking

MEDICAL CONDITIONS — CHECK ALL THAT APPLY

- ☐ Allergies / hay fever
- ☐ Cancer
- ☐ Congestive heart failure
- ☐ Angina
- ☐ Peripheral vascular disease
- ☐ Ulcer / esophagitis
- ☐ Bladder problems
- ☐ TIA / stroke
- ☐ Bipolar disorder
- ☐ Chronic fatigue
- ☐ Osteoporosis
- ☐ Thyroid disorder
- ☐ Asthma
- ☐ Chemotherapy / radiation
- ☐ Arrhythmia
- ☐ Coronary artery disease
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Anemia / bleeding or clotting disorder
- ☐ Multiple sclerosis
- ☐ ADHD
- ☐ Osteoarthritis / arthritis
- ☐ Fibromyalgia
- ☐ Chronic sinusitis
- ☐ COPD / bronchitis
- ☐ Heart attack / prior MI
- ☐ Murmur / MVP
- ☐ High blood pressure
- ☐ GERD / reflux
- ☐ Kidney disease / stones
- ☐ Epilepsy / seizures
- ☐ Depression
- ☐ Migraine headaches
- ☐ Rheumatoid arthritis
- ☐ Diabetes
- ☐ Other:

FINANCIAL POLICY & NOTICE OF PRIVACY PRACTICES/HIPAA

Payment for services are due at the time services are rendered.

If you have insurance, we will assist with filing claims as a courtesy. Your insurance contract is between you, your employer, and the insurance company; Suburban TMJ & Sleep Center does not contract with any insurance companies.

Not all services are covered by every insurance plan. Regardless of insurance coverage, the patient is responsible for all charges from the date services are rendered.

Patient Signature:

Date:

NOTICE OF PRIVACY PRACTICES / HIPAA ACKNOWLEDGMENT

Your health information is protected under HIPAA. The Center uses and discloses the minimum necessary information for treatment, payment, and healthcare operations, as permitted by law. You may review the Notice of Privacy Practices, request access to your records, and request restrictions or other privacy preferences as allowed by law. The Notice of Privacy Practices has been made available for your review.

☐ I acknowledge that the Notice of Privacy Practices was made available to me.

Patient Signature:

Date:

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www.suburbantmjcenter.com