



ADULT HEALTH QUESTIONNAIRE

Today's Date: _____

Demographic Information

Last Name: _____ Middle Initial: _____ First Name: _____

Single Married Widowed Separated Divorced

Age: _____ Date of Birth: _____ SSN #: _____ Sex: Male Female Other _____

Ethnicity: American Indian/Alaska Native Asian Black/African America Hispanic/Latino
 Native Hawaiian/Pacific Islander White Other Decline

Occupation: _____

Responsible Party/Legal Guardian (if different than patient): _____ Relationship to Patient: _____

Contact Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referral Information - How did you hear about us?

Referral Name/Source: _____

Referral Type: Doctor Dentist Specialist Patient Other _____

Provider Information

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

Additional Provider Office (if applicable): _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

Additional Provider Office (if applicable): _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

For Office Use Only - Date of Completion: _____

Patient Initials: _____

Current Symptoms

Reason(s) for this appointment: TMD / Pain Sleep / Airway Orthodontics Myofunctional Therapy

Please number your chief complaint as 1 and all other complaints starting at 2 and increasing numerically:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache (inside head) | <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Acid Indigestion |
| <input type="checkbox"/> Headache (outside head) | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Feeling Unrefreshed in Morning | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Snoring/Loud Breathing | <input type="checkbox"/> Nerve Pain |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Told I Stop Breathing | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Jaw Locking | <input type="checkbox"/> Nighttime Choking Spells | <input type="checkbox"/> Muscle Twitching |
| <input type="checkbox"/> Jaw Joint Noises | <input type="checkbox"/> Frequent Tossing & Turning | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Limited Ability to Open Mouth | <input type="checkbox"/> Repeated Awakening | <input type="checkbox"/> Sinus Congestion |
| <input type="checkbox"/> Difficulty Closing Mouth | <input type="checkbox"/> Nighttime Urination | <input type="checkbox"/> Dry Mouth Upon Wakening |
| <input type="checkbox"/> Pain When Chewing | <input type="checkbox"/> Kicking/Jerking Legs | <input type="checkbox"/> Sore Jaws Upon Wakening |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Morning Hoarseness in Voice |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Vivid Dreams | <input type="checkbox"/> Unable to Tolerate CPAP |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Affecting Sleep Partner | <input type="checkbox"/> Teeth Grinding |
| <input type="checkbox"/> Tinnitus (Ringing in Ears) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Prior Orthodontic Treatment |
| <input type="checkbox"/> Ear Congestion/Stuffiness | <input type="checkbox"/> Throat Pain | |

What is your level of head, neck, and facial pain? 0 = no pain to 10 = worst possible pain:

Currently: _____ At its best: _____ At its worst: _____

What results are you seeking from treatment? _____

Please check any dental symptoms that you have or are currently experiencing:

- Changes in bite Orthodontics Teeth Crowding Biting of Cheeks Teeth Spacing Broken Teeth
 Dental Changes Dentures Teeth Sensitivity Burning Mouth Dry Mouth Missing Teeth

Any symptoms not listed above? _____

- In which position do you sleep? back side stomach varies
 Where do you sleep? bed chair couch other
 Do you have a bed partner? yes no
 Is it easy for you to fall asleep? yes no
 How many times do you wake during the night? _____
 Do you feel rested upon waking? yes no
 Has anyone ever told you that you stop breathing during sleep? yes no
 Have you ever had a sleep study? yes no

If yes: Date: _____ Ordering Provider: _____

- Have you been prescribed a CPAP? yes no
 Do you use it as prescribed? yes no
 Have you had a previous oral appliance, mouthguard, splint, retainer? yes no
 Do you use it as prescribed? yes no
 How many hours of sleep, on average, do you get per night? _____
 How many hours of sleep, on average, during the day? _____
 Do you ever cough, gasp, or snort upon waking? yes no

Patient Initials: _____

Medications

Please list all medications you are currently taking and the reason you are taking them. Include prescription, over the counter, vitamins, herbs, etc. (Please attach additional sheet if necessary)

Medication	Dosage	Reason for Taking

Previous treatments/medications for the condition we are evaluating:

Treatment/Medication	Doctor/Provider	Approximate Date of Treatment

Do you take any sedatives/medications/supplements to help yourself fall asleep at night? yes no

If yes, what: _____

Pain & Sleep Therapy Center had my permission to obtain my complete medication history, including electronic submission.

Allergies

Do you have any known allergies/sensitivities to medications or your environment? Please List:

Other: _____

Medical History

Have you had prior orthodontic/braces treatment?

yes no

Have you had sustained injury to:

head face neck teeth

Other: _____

Please indicate if you have had any of the following:

___ General Anesthesia

___ Jaw Joint Surgery

___ Removal of Wisdom Teeth

___ Adenoids Removed

___ Orthognathic Surgery

___ Nasal Surgery

___ Tonsils Removed

___ Oral Surgery

Other Surgeries: _____

Do you have trouble breathing through your nose?

yes no

Are you currently pregnant?

yes no

Do you consume caffeine - if Yes, How Much?

yes no ___ How Much?

Do you smoke tobacco?

yes no

Do you consume alcohol?

yes no

if yes: habitually socially

Patient Initials: _____

Medical History, Continued

Please indicate if you have had any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Chronic Sore Throat | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Middle Back Pain |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Numbness in hands/fingers | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Swollen Gland | <input type="checkbox"/> Swelling in the neck | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Thyroid Enlargement | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Chronic Sinusitis |
| <input type="checkbox"/> Tightness in Throat | <input type="checkbox"/> Shoulder Stiffness | <input type="checkbox"/> Broken Teeth |
| <input type="checkbox"/> Constant Feeling of Foreign Object in Throat | <input type="checkbox"/> Tingling in hands or fingers | <input type="checkbox"/> Dry Mouth |
| <input type="checkbox"/> Limited Movement of Neck | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Frequent Biting of the Cheek |
| | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Burning Tongue Sensation |

Do you have or have you experienced any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disorder/Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Ovarian Cyst |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Bleeding Easily | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Postural Orthostatic Tachycardia Syndrome (POTS) |
| <input type="checkbox"/> Bruising Easily | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Recent Weight Gain |
| <input type="checkbox"/> Cholesterol (High/Low) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> History of Substance Abuse | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cold Hands and Feet | <input type="checkbox"/> Huntington's Disease | <input type="checkbox"/> Rheumatoid Fever |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Difficulty Breathing at Night | <input type="checkbox"/> Intestinal Disorder | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Significant Daytime Drowsiness |
| <input type="checkbox"/> Ehlers-Danlos Syndrome (EDS) | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sjogrens |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Slow Healing Sores |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Speech Difficulties |
| <input type="checkbox"/> Fluid Retention | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Frequent Awakening at Night | <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Swollen, Stiff, or Painful Joints |
| <input type="checkbox"/> Frequent Colds/Flus | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Muscle Fatigue | <input type="checkbox"/> Tired Muscles |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Frequent Sore Throat | <input type="checkbox"/> Muscle Tremors | <input type="checkbox"/> Urinary Tract Disorder |
| <input type="checkbox"/> Gastroesophageal Reflux (GERD) | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous System Disorder | |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Neuralgia | |

Does your family have a history of similar conditions, symptoms, or diseases? yes no Don't Know

If yes, who: _____

Patient Initials: _____

Currently Experiencing

Are you currently experiencing head pain? yes no

If yes, please indicate all that apply:

	Location			Time Frame		Severity			Duration			Frequency		
	Left	Right	Bilateral	Recent	Chronic (over 6 mo.)	Mild	Moderate	Severe	Min.	Hrs.	Days	Occasional	Frequent	Constant
Temple Area (Temporal)	<input type="checkbox"/>													
Back of Head (Occipital)	<input type="checkbox"/>													
Forehead (Frontal)	<input type="checkbox"/>													
Top of Head (Parietal)	<input type="checkbox"/>													
General Head Pain	<input type="checkbox"/>													

Are you currently experiencing jaw conditions? yes no

If yes, please indicate all that apply:

Jaw pain/tension with opening	<input type="checkbox"/> left	<input type="checkbox"/> right
Jaw pain/tension when chewing	<input type="checkbox"/> left	<input type="checkbox"/> right
Jaw pain/tension at rest	<input type="checkbox"/> left	<input type="checkbox"/> right
Jaw sounds with opening	<input type="checkbox"/> left	<input type="checkbox"/> right
Jaw sounds when chewing	<input type="checkbox"/> left	<input type="checkbox"/> right
Jaw sounds at rest	<input type="checkbox"/> left	<input type="checkbox"/> right

Please indicate if you have had any of the following:

<input type="checkbox"/> Jaw Locks Closed	<input type="checkbox"/> Nighttime Clenching/Grinding	<input type="checkbox"/> Pain/Pressure behind eyes
<input type="checkbox"/> Jaw Locks Open	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Extreme Sensitivity to light
<input type="checkbox"/> Daytime Teeth Clenching/Grinding	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Wear Glasses or Contact Lenses

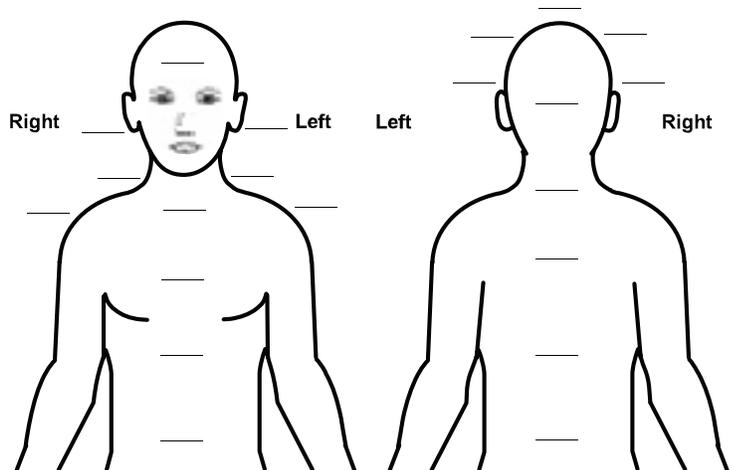
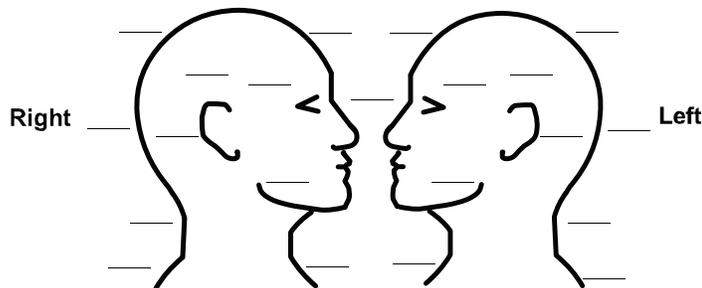
Are you currently experiencing any ear related conditions? yes no

If yes, please indicate all that apply:

Ear Congestion	<input type="checkbox"/> left	<input type="checkbox"/> right
Ear Pain	<input type="checkbox"/> left	<input type="checkbox"/> right
Hearing Loss	<input type="checkbox"/> left	<input type="checkbox"/> right
Itchiness or Stuffiness in Ears	<input type="checkbox"/> left	<input type="checkbox"/> right
Pain Behind the Ear	<input type="checkbox"/> left	<input type="checkbox"/> right
Pain in Front of the Ear	<input type="checkbox"/> left	<input type="checkbox"/> right
Recurrent Ear Infections	<input type="checkbox"/> left	<input type="checkbox"/> right
Ringing in the Ear	<input type="checkbox"/> left	<input type="checkbox"/> right

Please indicate your areas of pain by labeling the body and head diagrams with the appropriate numbers below.

1 - Mild Pain 2 - Moderate Pain 3 - Severe Pain



Patient Initials: _____

Symptom History

On what date, or approximate date, did your condition/symptoms first occur? _____

Can you relate your pain/condition to a motor vehicle accident or traumatic injury? yes no

If yes, please explain: _____

Does any family member have a sleep breathing disorder or Obstructive Sleep Apnea? yes no

If yes, who: _____

Does any family member have the same or a similar problem? yes no

If yes, please explain: _____

GAD-7 Anxiety

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Patient Initials: _____

Have you ever experienced: ___Physical Abuse ___Verbal Abuse ___Emotional Abuse ___Sexual Abuse ___None
 (Optional - check applicable)

If yes, please explain (optional): _____

PHQ - 9

Over the last 2 weeks have you been
 bothered by any of the following problems?
 (use "X" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL please refer to the accompanying scoring card).

TOTAL

<p>10. If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p style="text-align: right;">Not difficult at all _____</p> <p style="text-align: right;">Somewhat difficult _____</p> <p style="text-align: right;">Very Difficult _____</p> <p style="text-align: right;">Extremely difficult _____</p>
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Patient Initials: _____

