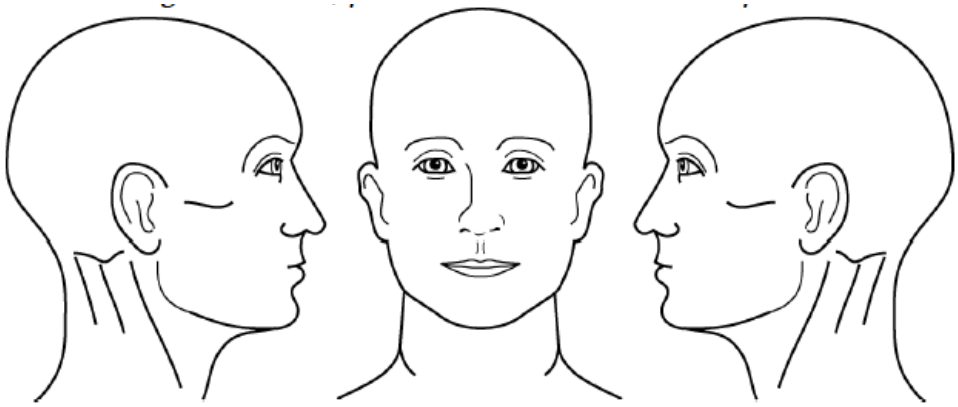
PATIENT NAME:_____ DATE:_____

EMAIL ADDRESS:_____@_____

ADDRESS:_____CITY:_____
STATE:_____ZIP:_____ Primary PHONE:_____
SOCIAL SECURITY #:_____AGE:_____ DOB___/___/_____
SEX: M F HEIGHT:_____ WEIGHT:_____

On the diagram below, shade the area and rate the severity from 0 to 10 (0=none 10=most severe) of your present pain/symptoms, describing each as A=achy P=pressure D=dull S=sharp T=throbbing B=burning T=tight



Date when your pain/symptoms **originally,** first began:_____
Date of this **current** episode:_____

When is the pain/symptom present? *Constantly* *Frequently* *Infrequently*
How often do you have it? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% of the day.

What symptoms are you currently experiencing in your jaw? (R-Right or L-Left):
Clicking R L *Popping R L* *Grating sound R L* *Pain R L* *Sticking/locking R L*

Other:_____
What caused it? _____
What makes it feel better?_____
What makes it feel worse?_____
What treatments have you received?_____
_____ _____
When are the symptoms worse? Upon awakening Later in day Other:_____
What do the symptoms keep you from doing?_____

Describe your daily stress level: *High* *Moderate* *Mild* *None*

Does the pain/symptoms:

Wake you up at night?	Yes No
Increase when you lie down?	Yes No
Increase when you bend forward?	Yes No
Increase when you drink hot or cold beverages?	Yes No
Increase when you eat or chew?	Yes No
Increase when swallowing or turning your head?	Yes No
Increase after reading or straining your eyes?	Yes No

YES NO Inability to open mouth smoothly? R or L
YES NO Mouth stuck or locked? *Open or Closed*
YES NO Have you ever been unable to open your mouth wide? When:_____
YES NO Have you ever been unable to close your mouth? When:_____
Describe any other symptoms you associate with the problem:
_____
_____
_____
What treatment do you think is needed for your problem?_____

Is there anything else you think we should know about your problem?_____
_____

Have you ever been treated for this before? When?_____Duration:_____
By whom?_____What was the treatment?_____
Outcome?_____

Have you been prescribed to a mouth guard, night guard, splint, or appliance? Yes No
Do you still wear it? Yes No Worn it for how long?_____

YES NO Have you noticed any sense of an altered **bite**, altered jaw posture or altered jaw function during chewing, speech or other mouth movement?

YES NO Have you noticed any symptoms associated with your **ears**? (circle)
diminished hearing, ringing, buzzing, hissing, roaring, sense of pressure
pain without infection stuffiness or clogged feeling

YES NO Have you noticed any symptoms associated with your e**yes**?
pain above, below, behind eyes bloodshot eyes blurred vision difficulty moving eyes
bulging eyes pressure behind eyes watering of eyes drooping of eyelids

YES NO Have you noticed any symptoms associated with your **throat**?
swallowing difficulties tightness sore throat voice fluctuations laryngitis
frequent coughing/clearing throat tongue pain/burning feeling of foreign object in throat
excess salivation pain in hard palate

YES NO Have you noticed that any of the symptoms in the head, neck, and shoulder region that you are experiencing are **increased** following speech, chewing, yawning, etc.
YES NO Movement difficulties of your eyes, tongue, facial muscles, or making an expression?
YES NO Numbness or tingling of face? R L

YES NO Numbness or tingling in hands? R L
YES NO Problems (pain, looseness, sensitivity) with your teeth? Which ones?_____
YES NO Have you noticed any tendency to clench your teeth?
YES NO Does one side of teeth/molars touch before the other?*Right or Left side*
YES NO Swelling over your jaw joint or in your mouth or throat?
YES NO A certain spot that triggers your pain/symptom? Where?_____
YES NO Do you have dizziness or balance problems or vertigo?
YES NO Do you breathe with an open mouth?
YES NO Do you sleep well at night?
YES NO Does your partner tell you that you grind your teeth at night?
YES NO Do you snore? Nightly? yes or no
YES NO Do you have Sleep Apnea

YES NO Do you have headaches? How often?_____When? AM or PM
YES NO Do you have cheek pain? *Right or Left side*
YES NO Do you have neck pain? *Right or Left side*
YES NO Do you have low back pain? *Right or Left side*
YES NO Do you have tailbone pain?
YES NO Are you aware of clenching or grinding your teeth when: (circle)
sleep driving using computer/device at other times
What % of the day are your teeth touching? _____%

Are you aware of oral habits such as: *chewing your cheeks biting lip/cheek pushing tongue against teeth or roof of mouth chewing on objects sucking mints/candy biting your nails/cuticles tapping your teeth together thrusting out your jaw not aware*

Do you CURRENTLY have:
YES NO Fever?
YES NO Nasal Congestion or stuffiness?
YES NO Recurrent swelling or tenderness of joints *other* than in your jaw joint?
YES NO Morning stiffness in your body, other than your jaw?
YES NO Muscle tenderness in your body other than in your face/head/neck for more than 50% of the day? Where?_____
YES NO Do you play a wind instrument, talk continuously, or sing more than 5 hours a week?

How often are you tense, aggravated, stressed, or frustrated during a usual day?
always half the day seldom never
How often do you feel depressed, sad, blue, or listless during a usual day?
always half the day seldom never
Do you have suicidal thoughts or thoughts of hurting others? YES NO

Have you ever had in the PAST:

YES NO Jaw Pain? R L
YES NO Jaw Joint Noise? R L
YES NO Limited opening/movement? R L
YES NO Jaw sticking/locking/dislocation R L
YES NO Changes in bite position R L
YES NO Stiff/tight or tired jaw? R L
YES NO Jaw injury or dislocation? R L
YES NO Braces and or neck/headgear? How long? *1 year 2 years 3 years 4 year 5+*
YES NO An injury/fall on tailbone? (ex. snowboarding, horseback riding, sat down hard)
YES NO Painful opening/closing of mouth? R L
YES NO Facial pain/tightness? R L
YES NO Headaches R L
YES NO Ear pain R L
YES NO Stuffiness in ears? R L
YES NO Tinnitus/Ringing in ears R L
YES NO Vertigo/Dizziness R L
YES NO Difficulty Swallowing R L
YES NO History of whiplash, neck injury R L
YES NO Surgery to jaw, neck or head? When and Why:_____
YES NO AutoAccident? When:_____
YES NO Slip and fall, or other accident? When:_____
YES NO Decreased range of motion with neck R L
YES NO Chronic low back pain R L
YES NO More recent injury to head, neck, low back or jaw? When?_____
YES NO Chronic Fatigue
YES NO Disequilibrium/Discoordination
YES NO Mental Confusion
YES NO Irritability
YES NO Bell's Palsy R L
YES NO Trigeminal Neuralgia/Tic Douloureux R L
YES NO Shingles on your head or neck?

I certify that the above information and the information on the past history form is complete and accurate to the best of my knowledge. I agree to notifhy this doctor immediately whenever I have changes in my health condition in the future.

*Patient's Signature:*_____*Date:*_____

MINOR CONSENT:

I, _____, being the legal guardian of _____, authorize to seek, obtain and consent to, for as deemed necessary by Dr. Kimberly Bensen, DC. This authorization is for the time period when my child is in care of Dr. Bensen, from ___/___/20__ until revoked by me.

Parent/Guardian Information:

Full Name:_____ Phone Number:_____
Address:_____

Other Parent/Guardian Information: (if necessary)

PAST	NOW	CONDITION	PAST	NOW	CONDITION
		chest pains			bladder infection
		loss of appetite			kidney disorders type:_____
		anorexia			colitis
		chronic cough			irritable colon
		dermatitis/eczema/rash			HIV/AIDS
		abnormal weight gain/ loss			drug or alcohol dependence
		chronic sinusitis			**ALL** MEDICATIONS
		general fatigue			List:_____ _____
		irregular menstrual flow			_____ _____
		breast soreness or lumps			HOSPITALIZATIONS /SURGERIES
		endometriosis or PMS			_____ _____
		loss of bladder control			_____ _____
		painful urination			_____ _____
		frequent urination			**FAMILY HISTORY**
		abdominal pain			Rheumatoid Arthritis
		constipation/irregular bowel habits			high blood pressure heart problems
		difficulty in swallowing			Ehlers Danlos, Marfans, hypermobility disorders
		heartburn or indegestion			cancer, type:_____
		pregnancy #births:_____			chronic back problems
		birth control pills			headaches, migraines
		hepatitis type:_____			TMJD, Jaw problems

Full Name:_____ Phone Number:_____
Address:_____
PATIENT NAME:_____DATE:_____

If you have ever had a listed symptom in the PAST, please check that symptom in the Past Column. If you are presently troubled by a particular symptom, check that symptom in the NOW Column.

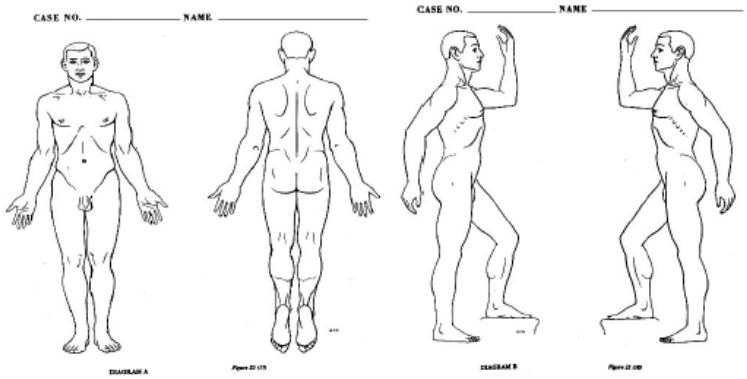
KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.

PAST	NOW	CONDITION	PAST	NOW	CONDITION
		neck pain			depression, anxieties, anxiousness
		traps/ shoulder pain R or L			aortic aneurysm
		upper arm/elbow pain R or L			high blood pressure
		hand pain R or L			angina
		wrist pain R or L			heart attack date:_____
		upper back pain			stroke date:_____
		lower back pain			asthma
		upper leg/hip pain R or L			cancer date:_____ type:_____
		low leg/knee pain R or L			tumor type:_____
		ankle/foot pain R or L			prostate problems
		swelling/stiffness of joints where:_____			blood disorders
		visual disturbances			emphysema (chronic lung)
		convulsions			Ehlers Danlos, Marfans, Hypermobility disorder
		dizziness or vertigo			rheumatoid arthritis
		headache			diabetes
		osteoarthritis			epilepsy
		muscular incoordination			ulcer
		tinnitus or ringing in ears			liver/gallbladder problems
		rapid heart beat			kidney stones

Describe ***ANY ADDITIONAL*** Present Complaints, Other Than TMJ

Please check all your answers and fill in the blanks where appropriate.
Date problem began: ___/___/_____ Describe your problem and how it began:

_____
_____
_____



Mark and rate the severity from 0 to 10 (0=none 10=most severe) of your pain/symptoms on the body picture above where the additional problem(s) is/are:

How often are your symptoms present? (circle corresponding)
Constantly Frequently Occasionally Intermittent
Describe your current pain/symptoms:
Sharp Stabbing Throbbing Achy Dull Soreness Weakness
Numbness Shooting Burning Tingling Other:_____
Since it began, is your problem:
Improving Getting Worse No Change
What makes the problem better?
Walking Lying Down Standing Sitting Movements Exercise Inactivity/Rest Other
What makes the problem worse?
Walking Lying Down Standing Sitting Movements Exercise inactivity/Rest Other

Can you perform your daily activities? *Yes Yes with help Not at all*
Describe your job requirements: *Heavy Labor Light Labor Mainly Sitting Mainly Standing*
Can you perform your work activities? *Yes, all activities Only some Not at all*
Describe your stress level: *High Moderate Mild None*

What treatment have you had for this condition in the past?
Surgery Medications Injections Physical Therapy Chiropractic Adjustments
_____
_____
What tests have you had for this condition:
X-rays MRI Scans Other:_____ Dates Taken:_____