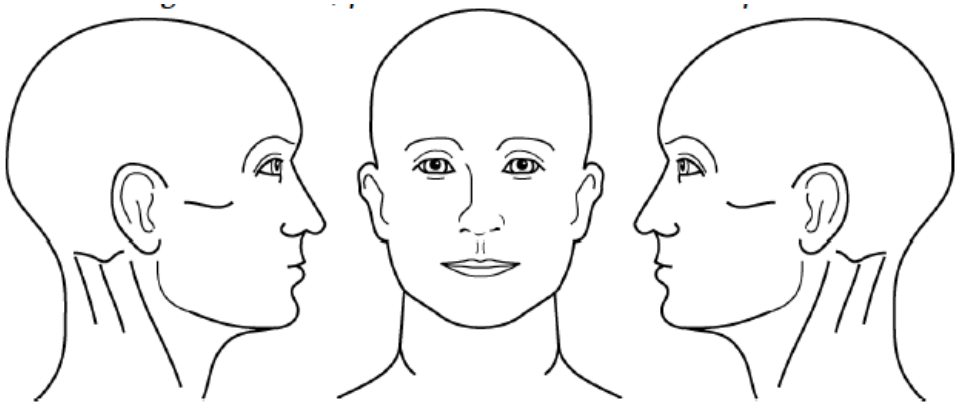
PATIENT NAME:_____ DATE:_____

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 Th=throbbing B=burning T=tight



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

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.

Do you currently experience any of these sounds/feelings 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*
How long have you had these sounds/feelings in your jaw?_____

Is there a certain spot that triggers your pain/symptom? Y N Where?_____
What time of day is it worse? *morning* *afternoon* *evening* *middle of night*

What makes it feel better?_____
What makes it feel worse?_____

What do the symptoms keep you from doing?_____
_____

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

Circle YES or NO under the **NOW** heading on the left, and if indicated, under the **PAST** heading on the right. Circle, when applicable, which choice in ***italics*** best describes your answer.
R=right, L=left

NOW	
YES NO	Wake up with pain/tightness in cheeks, jaw, temples
YES NO	Wake up with teeth sensitivity to temperature
YES NO	Wake up with stiff jaw, decreased range of comfortable opening
YES NO	Wake up irritable, grouchy, anxiety
YES NO	Symptoms increase when eating or chewing
YES NO	Prescribed a mouth guard, night guard, splint, appliance
YES NO	Still using it? Worn it for how long?_____
YES NO	Bite on nails, cuticles, lip, cheeks, objects, gum, sunflower seeds
YES NO	Leaning jaw/head on palm of hand
YES NO	Pushing tongue against front teeth or roof of mouth
YES NO	Use teeth as tool/scissors to tear packaging, thread
YES NO	Sense of an altered **bite**, altered jaw posture or altered jaw function during chewing, speech or other mouth movement
YES NO	Play a wind instrument, talk continuously, or sing more than 5 hrs/week
YES NO	Jaw
YES NO	Clench or grind teeth when: (circle) *sleep driving using computer/device at other times* What % of the day are your teeth touching? _____%

	NOW		**PAST**
R L	YES NO	Jaw Pain	YES NO
R L	YES NO	Pain in cheek muscles	YES NO
R L	YES NO	Jaw joint noise	YES NO
R L	YES NO	Limited opening/movement?	YES NO
R L	YES NO	Jaw sticking/locking/dislocation	YES NO
R L	YES NO	Uncontrollable jaw and/or tongue movements	YES NO
R L	YES NO	Inability to open mouth smoothly?	YES NO
	YES NO	Mouth stuck or locked *Open Closed*	YES NO
	YES NO	Unable to open mouth wide?	YES NO
.		When:_____	
	YES NO	Unable to close your mouth?	YES NO
		When:_____	
R L	YES NO	Painful opening/closing of mouth	YES NO
R L	YES NO	Changes in bite position	YES NO
R L	YES NO	Stiff/tight or tired jaw	YES NO
R L	YES NO	Jaw injury or dislocation	YES NO
R L	YES NO	Braces and or neck/headgear	YES NO
		How long? *1 year 2 years 3 years 4 years*	

	NOW		PAST
R L	YES NO	Facial pain/tightness?	YES NO
R L	YES NO	Headaches AM or PM	YES NO
	Type: *sinus migraine cluster ocular stress frontal*		
R L	YES NO	Hit in the face or head	YES NO
R L	YES NO	Shooting pain up back fo head	YES NO
R L	YES NO	Hair and/or scalp painful to touch	YES NO
	YES NO	Pain, looseness, sensitivity Which ones?_____	YES NO
	YES NO	Clench teeth during day or night	YES NO
	YES NO	Grinding teeth during day or night	YES NO
R L	YES NO	One side of teeth/molars touch before the other	YES NO
	YES NO	Sensitivity with hot/cold beverages	YES NO
	YES NO	Swelling over jaw joint	YES NO
	YES NO	Swelling inside mouth or throat	YES NO
R L	YES NO	Ear pain, ache, no infection	YES NO
R L	YES NO	Stuffiness in ears	YES NO
R L	YES NO	Clogged, dampening sound	YES NO
R L	YES NO	Itchy ears	YES NO
R L	YES NO	Hissing/buzzing/ringing	YES NO
R L	YES NO	Vertigo/Dizziness	YES NO
R L	YES NO	Pain/pressure above, below, behind eyes	YES NO
R L	YES NO	Bloodshot eyes	YES NO
R L	YES NO	Blurred vision	YES NO
R L	YES NO	Difficulty moving eyes	YES NO
R L	YES NO	Watering of eyes	YES NO
R L	YES NO	Drooping of eyelids	YES NO
	YES NO	Difficulty Swallowing	YES NO
R L	YES NO	Hoarse or one sided sore throat	YES NO
	YES NO	Laryngitis, voice irregularities	YES NO
	YES NO	Frequent coughing/clearing throat	YES NO
R L	YES NO	Feeling of foreign object in throat	YES NO

	NOW		PAST
	YES NO	Symptoms increase bending forward	YES NO
	YES NO	Increase when swallowing	
R L	YES NO	Increase when turning head	YES NO
	YES NO	Increase when laying down	YES NO
	YES NO	Increase after reading/straining eyes	YES NO
	YES NO	*Dizziness balance problems vertigo*	YES NO
R L	YES NO	Numbness or tingling in hands	YES NO
	YES NO	Symptoms in head, neck, and shoulder	YES NO

i**ncreased** following speech, chewing, yawning, etc.

R L	YES NO	Do you have cheek pain	YES NO
R L	YES NO	Do you have temple pain	YES NO
R L	YES NO	Do you have neck pain	YES NO
R L	YES NO	Do you have low back pain	YES NO
R L	YES NO	Do you have tailbone pain	YES NO
R L	YES NO	An injury/fall on tailbone	YES NO

(example: snowboarding, horseback riding, missed chair, sat down hard)

	NOW		**PAST**
R L	YES NO	History of whiplash, neck injury	YES NO
R L	YES NO	Surgery to jaw, neck or head?	YES NO
		When:_____Why:_____	
R L	YES NO	Tired, sore muscles constantly:	YES NO
		neck shoulders mid back low back	
R L	YES NO	Hand/finger numbness/pain	YES NO
R L	YES NO	Decreased range of motion in neck	YES NO
R L	YES NO	Decreased range of motion in low back	YES NO
	YES NO	Chronic fatigue	YES NO
	YES NO	Movement difficulties of eyes, tongue, facial muscles, or making an expression?	YES NO
R L	YES NO	Numbness or tingling of face?	YES NO
R L	YES NO	Bell's Palsy	YES NO
R L	YES NO	Trigeminal Neuralgia/Tic Douloureux	YES NO
R L	YES NO	Shingles on head or neck	YES NO

YES NO Auto Accidents When:_____
Treatment received_____

YES NO Slip and fall, or other incident? When:_____
Treatment received_____

YES NO Injury to: *head, neck, low back, shoulder, jaw* When?_____
Treatment received_____

NOW		**PAST**
YES NO	Constant waking up in middle of night	YES NO
YES NO	Do you breathe with an open mouth	YES NO
YES NO	Do you have sleep apnea	YES NO
YES NO	Do you use a CPAP type machine or appliance	YES NO
YES NO	Do you sleep well at night	YES NO
YES NO	Does your partner tell you that you grind your teeth at night	YES NO
YES NO	Do you snore nightly	YES NO
YES NO	Crave sweets, feel faint when hungry, sleepy right after eating, irritable when hungry	YES NO

NOW

YES NO Disequilibrium/Discoordination
YES NO Mental Confusion
YES NO Irritability
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 have suicidal thoughts or thoughts of hurting others?

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*

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?_____

I certify that all information in these 8 pages is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.
Patient's Signature:_____Date:_____8__

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)
Full Name:_____ Phone Number:_____
Address:_____

*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.

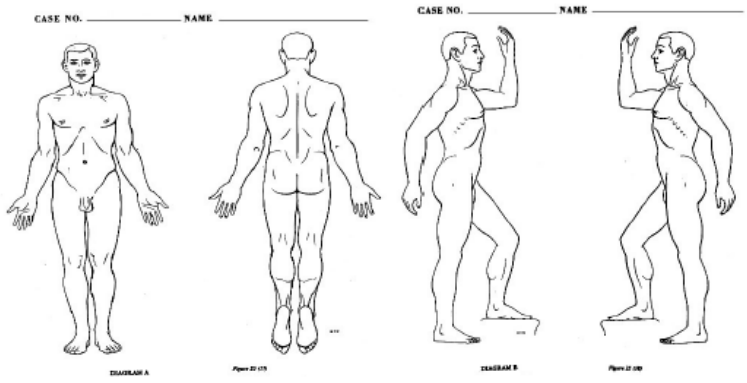
PAST	NOW	CONDITION	PAST	NOW	CONDITION
		allergies (to what): _____			chronic cough
		asthma			aortic aneurysm
		emphysema			high blood pressure
		COPD (chronic obstructive pulmonary disease)			angina
		chronic sinusitis			heart attack date:_____
		hand pain R or L			stroke date:_____
		wrist pain R or L			chest pains
		upper arm/elbow pain R or L			Blood disorders
		ankle/foot pain R or L			
		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			epilepsy
		blood sugar issues:diabetes, hypoglycemina, hyperglycemia			endometriosis or PMS
		osteoarthritis, degenerative joint disease, disc problems			irregular menstrual flow
		rheumatoid arthritis			breast soreness or lumps
		Ehlers Danlos, Marfans, Hypermobility disorder			pregnancy #births:_____
		loss of appetite			bladder infection
		anorexia/bulimia			kidney disorders type:_____

PAST	NOW	CONDITION	PAST	NOW	CONDITION
					colitis
		depression, anxieties, anxiousness			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

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:_____