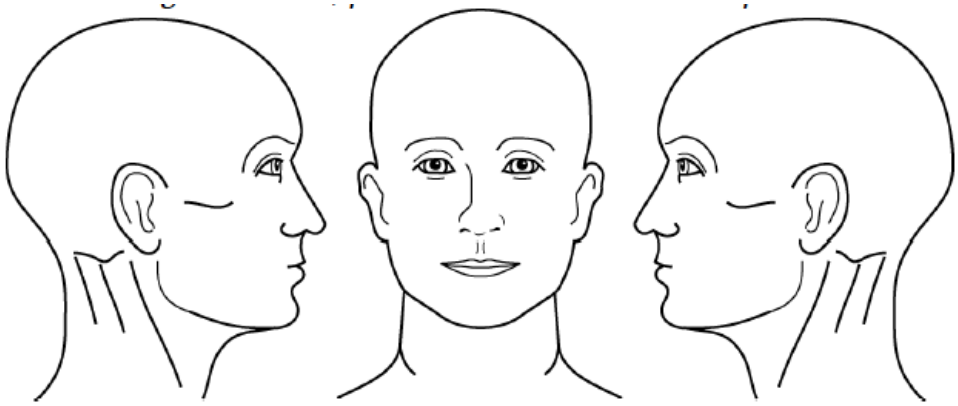
PATIENT NAME:_____ DATE:_____

EMAIL ADDRESS:_____@_____

ADDRESS:_____CITY:_____

STATE:_____ZIP:_____ Primary PHONE:_____
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	Clench or grind teeth when: (circle) *sleep driving using computer/device at other times*
YES	NO	Are your teeth touching during the day? What % of the day? _____%

	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? When:_____	YES NO
	YES NO	Unable to close your mouth? When:_____	YES NO
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
	YES NO	Braces *How long? 1 year 2 years 3 years 4 years ++*	YES NO
	YES NO	Wore Head/Neck gear	YES NO

	NOW			PAST
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
R L	YES NO	Facial pain/tightness?		YES NO
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)			
	YES NO	Pain, looseness, sensitivity in a tooth Which one(s)?_____		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 molars touch before 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
	YES NO	Movement difficulties of eyes, tongue, facial muscles, or making an expression?		YES NO

	NOW		PAST
	YES NO	Increase bending forward	YES NO
	YES NO	Increase when swallowing	YES NO
R L	YES NO	Increase when turning head	YES NO
	YES NO	Increase following speaking, chewing, yawning, etc.	YES NO
	YES NO	Increase when laying down	YES NO
	YES NO	Increase after reading/straining eyes	YES NO
R L	YES NO	History of whiplash, neck injury	YES NO
R L	YES NO	Surgery to jaw, neck or head? When:_____Why:_____	YES NO
R L	YES NO	Tired, sore muscles constantly: *neck shoulders mid back low back*	YES NO
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
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 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): _____			hearing problems, loss, hyperacusis
		asthma			sinusitis
		emphysema			high blood pressure
		COPD (chronic obstructive pulmonary disease)			aortic aneurysm
		chronic sinusitis			heart attack date:_____
		hand pain R or L			stroke date:_____
		wrist pain R or L			chest pains, angina
		upper arm/elbow pain R or L			Blood disorders
		ankle/foot pain R or L			HIV/Aids
		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:_____
		cold sores, fever blisters, herpes			bladder infection
		anorexia/bulimia			kidney disorders type:_____

past	now	CONDITION	past	now	CONDITION
		depression, anxieties, anxiousness			**LIST ALL MEDICATIONS**
		dermatitis/eczema/rash			
		abnormal weight gain/loss			
		chronic sinusitis			
		general fatigue			**LIST ALL INJURIES**
		irregular menstrual flow			
		breast soreness or lumps			
		endometriosis or PMS			
		loss of bladder control			**HOSPITALIZATION/SURGERIES**
		painful urination			
		frequent urination			
		abdominal pain			
		constipation/irregular bowel habits, IBS, colitis			**FAMILY HISTORY**
		hepatitis type:_____			Ehlers Danlos, Marfans, hypermobility disorders
		heartburn or indegestion			cancer, type:_____
		pregnancy #births:_____			chronic back problems
		birth control pills			headaches, migraines
		Diagnosed with any thing else: _____ _____ _____			TMJD, Jaw problems Rheumatoid Arthritis high blood pressure heart problems

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

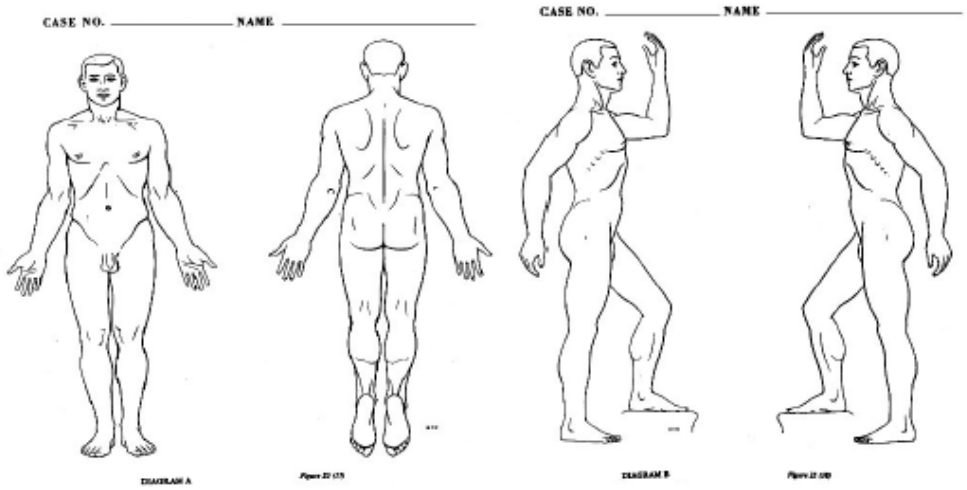
Please check all your answers and fill in the blanks where appropriate.
Date problem began: ___/___/_____ Describe your problem and how it began:

_____

_____

_____

On the body below, **"X"** where symptom is, then rate the severity from **0 to 10** (0=none 10=most severe)



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:_____*