TruDenta

HEAD HEALTH HISTORY

PATIENT INFORMATION

NAME	DATE TODAY / /	AGE	SEX	TELEPHONE

#	DENTAL FOUNDATION (TEETH, MUSCLES, JOINTS)		
1	Have you noticed a change in the way your teeth fit together? » If 'Yes', it is because of ☐ Dental Changes ☐ Trauma ☐ Other	☐ Yes	☐ No
2	Where do you think your teeth hit or fit first? ☐ More on the right ☐ Left ☐ Equal ☐ More on the front ☐ Back ☐ Equal		
3	Do your jaw muscles get tight or sore? » When? ☐ Morning ☐ Evening ☐ After chewing	☐ Yes	☐ No
4	Do you have pain or difficulty opening wide?	☐ Yes	☐ No
5	Are you aware of noises in your jaw joints? ☐ Popping ☐ Clicking ☐ Other » Where? ☐ Right ☐ Left ☐ Both » How long? ☐ Less than 1 year ☐ More than 1 year	☐ Yes	☐ No
	CAUSES & COMPLICATIONS		
6	Do you grind or clench your teeth? » Do you wear a? ☐ Splint ☐ Night Guard ☐ Retainer	☐ Yes	☐ No
7	Have you had any significant dental treatments? ☐ Orthodontics ☐ Oral surgery / wisdom teeth removal ☐ Long dental appointments ☐ Other	☐ Yes	☐ No
8	Have you been in a car accident, major or minor? » How many? _____ » When was the last accident? ☐ 0-6 Months ☐ 6-12 Months ☐ More than 1 year » Did you see the accident coming? ☐ Yes ☐ No » Did the airbag deploy? ☐ Yes ☐ No	☐ Yes	☐ No
9	Have you had sports injuries and/or trauma to your head & neck? » When? ☐ Less than 1 year ☐ More than 1 year	☐ Yes	☐ No
10	Do you work at a desk, computer or in a forward head posture position? » Do you have any other postural position problems? _____	☐ Yes	☐ No
11	Daytime sleepiness, drowsiness, or tiredness?	☐ Yes	☐ No
12	Problems with sleep? » Insomnia ☐ Yes ☐ No » Sleep Apnea ☐ Yes ☐ No » Sleep Disturbances ☐ Yes ☐ No » Less than 7 hours per night ☐ Yes ☐ No » Other _____		

#	SYMPTOMS
13	Do you experience pain in » Jaw ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Face ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Neck ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Shoulders ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Arms ☐ Right ☐ Left ☐ Both ☐ More than 1 year
14	Do you experience ringing or fullness in your ears? ☐ Yes ☐ No » Which one? ☐ Right ☐ Left ☐ Both
15	How often do you get severe headaches/migraines that makes it difficult to function without treatment or medication? ☐ Occasionally ☐ More than twice a year ☐ More than once a month ☐ More than once a week ☐ Never
16	How often do you get other milder headaches? ☐ Daily ☐ More than 3 per week ☐ More than 2 per month ☐ Other _____
17	Have your headaches changed in the last six months? ☐ About the same ☐ Slight worsening ☐ Same but more frequent ☐ A lot worse Got worse when _____
	IMPACT ON DAILY LIVING ACTIVITIES
18	What is your stress level? ☐ Mild ☐ Moderate ☐ Severe
19	Do you have anxiety? ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe
20	Because of pain, headaches or migraines, in the last month: # Of days you could not go to school _____ # Of days you did reduced amount of work _____ # Of days you could not do usual household work/parenting _____ # Of days you missed family or social functions _____
21	When you have pain, headaches or migraines, how does that make you feel? *(Check all that apply)* ☐ Angry ☐ Depressed ☐ Tired or exhausted ☐ Frustrated ☐ Guilty ☐ Ashamed ☐ Relationship tension ☐ Other _____
22	How many days per month are you: Pain Free? _____ Headache Free? _____
	NOTES: _____