Patient Contact Information

Date:

Name | DOB | Gender

Address | City | State

Email | Zip

Phone | Type | Can we leave message? ☐ Yes ☐ No

Employment | Occupation Type

Emergency Contact Information

☐ None

Name | DOB | Gender

Address | City | State

Phone | Zip

Parent/Guardian/Spouse/Partner
(Must be complete if patient is under 18.)

☐ **Not a minor nor need a guardian**

Name | Relationship

All information is the same as Patient above: ☐ Same as above

Address | City | State

Phone | Zip

Physician/Primary Care Information

☐ None

Name | Office

Address | City | State

Phone | Zip

☐ **Medical information can be shared with this physician if request by patient/office**

Dentist Information	☐ None				
Name		Office			
Address		City		State	
Phone				Zip	

☐ **Medical information can be shared with this physician if request by patient/office**

I/We authorize *The Craniofacial and TMJ Institute* to release all medical information and/or records to my requesting insurance company and/or referring physician/dentist (if referred from a physician/dentist).

☐ **I agree to release of information**

Patient Signature/Electronic Signature

Date

Patient Questionnaire	☐ None
From whom did you hear about us?	
Referred By	

Are you currently pursuing or contemplating litigation for your condition for which you are seeking treatment (e.g. lawsuit, disability or workman's compensation). ☐ Yes ☐ No

If so which type

Patient History

History of current condition - Describe location, intensity, duration, and onset of condition.
(Please limit text to size of box seen)

Please indicate the areas you are having pain:

Left Side of Face	Worst on Left	Right Side of Face	Worst on Right
☐ Top of head	☐	☐ Top of head	☐
☐ Eye	☐	☐ Eye	☐
☐ Nose	☐	☐ Nose	☐
☐ Cheek	☐	☐ Cheek	☐
☐ Jaw	☐	☐ Jaw	☐
☐ Chin	☐	☐ Chin	☐
☐ Mouth	☐	☐ Mouth	☐
☐ Neck	☐	☐ Neck	☐
☐ Shoulder	☐	☐ Shoulder	☐

Please rate the intensity of your pain at its worse below:

What has made your pain worse?

Please rate the intensity of your pain at its best below:

Headache History

Do you have headaches? ☐ Yes ☐ No

Please complete following questions if you answered **yes**. If you answered **no** skip to next section.

Are they recurrent? ☐ Yes ☐ No How often?

Are there known triggers? ☐ Yes ☐ No

If yes list.

Have you missed work/school? ☐ Yes ☐ No

Does the pain ☐ Radiate ☐ Stay in place How long does it last? ▼

Does the headache cause you to vomit? ☐ Yes ☐ No

Does the headache cause visual issues? ☐ Yes ☐ No

Dental/Facial History – Please Check All That Apply

☐ Night splint/retainer	☐ Recurrent sinus infections	☐ Sinus Surgery
☐ Licking lips/sticking tongue out	☐ Pre-mature closure of cranial sutures	☐ Palate Expender
☐ Grind or clench teeth	☐ Orthognathic Surgery/Jaw Surgery	☐ Jaw lock
☐ Extensive dental work at one time	☐ Licking lips/sticking tongue out	☐ Braces
☐ TMJ Pain/Dysfunction	☐ Chewing on objects or lips, cheeks, tongue	☐ Biting finger nails
☐ Popping or clicking in jaw	☐ Tonsils/Adenoids removed	☐ Wisdom teeth removal
☐ Recurrent ear infections	Other:	

When you have pain, where is it predominantly? – Please Check All That Apply

☐ Forehead/Temple area	☐ Throat	☐ Lips
☐ Eye	☐ Teeth	☐ Chin
☐ Nose	☐ Tongue	☐ Mouth
☐ Cheek	☐ Tonsils	
☐ Jaw	Other:	
☐ Upper (near ear)	Other:	
☐ Lower (near chin)		

Do you remember when and where your facial pain started? ☐ Yes ☐ No

If so when?

Did you have a trauma or stressful event surrounding the onset of the pain? ☐ Yes ☐ No

Was the pain: ☐ gradual ☐ sudden

Is the pain ☐ consistent ☐ intermittent

Is the pain consistently felt in the same area ☐ Yes ☐ No

If No how does it move or change?

Does the pain feel ☐ Superficial - on the skin ☐ Deep - "in the bone"

Do you have pain just on one side of your face? ☐ Yes ☐ No ☐ Sometimes

Type of sensations – Please Check All That Apply

☐ Electrical ☐ Shocking ☐ Dull

☐ Stabbing ☐ Shooting ☐ Burning

☐ Throbbing ☐ Twitching ☐ Tingling

Can your pain start by something touching your face (for example, by eating, washing your face, shaving, brushing your teeth, and/or wind?) ☐ Yes ☐ No

Is your facial pain accompanied with a headache? ☐ Yes ☐ No

PAST HISTORY

Any special tests that have been performed, the body part tested, and the results. (ie: X-ray, MRI, CT Scan. If yes, please bring in a copy if possible.) ☐ None

***If you have had recent x-ray's completed at your dentist please request for them to email them to us: Kristie@thecraniofacialinstitute.com**

Have you had any other treatments for your current condition? (ie: PT, Chiropractic, Massage, Acupuncture) Please list practitioners. ☐ None

Have you been advised to have any surgery that has not been done? When and what? ☐ None

Please list all previous injuries, accidents, surgeries and any other pertinent medical information. (Please include dates and type of surgery. This include sinuplastiy, orthognathic surgery, tonsillectomy and/or adenoidectomy. If possible please bring in a copy of the operative report.) ☐ None

Please list *all* current medications, vitamins, and/or supplements. ☐ None

Please list *all* allergies including any latex, gels creams, adhesives or nickel allergies. ☐ None

Do you currently have any metal, plastics or implants anywhere in your body? (Including breast, cheek, nose, teeth, or joint replacements. (If possible please bring in a copy of the operative reports and/or images.)
☐ None

Have you ever been?

Knocked Unconscious ☐ Yes ☐ No How many times?

When?

Knocked in Head Hard ☐ Yes ☐ No How many times?

When?

Scuba Diving ☐ Yes ☐ No How often? How deep?

Flown in a plan more than 7 times within a year ☐ Yes ☐ No

Motor Vehicle Accident ☐ Yes ☐ No How many times? When?

Do you or have you ridden? – Please Check All That Apply ☐ None

☐ Horses	☐ ATV	☐ Tubing
☐ Motorcycle	☐ Mountain biking	☐ Skiing: water or snow
☐ Skate boards	☐ Roller/Ice Skates	

Do you now have or have you had any of these symptoms in the past year? – Please Check All That Apply

☐ None	☐ Difficulty sleeping	☐ Osteoporosis/Osteopenia
☐ Brain fog	☐ Fainting spells	☐ Persistent joint pain
☐ Blood in bowel/urine	☐ Hot flashes	☐ Psychological Trauma
☐ Change in bowel movements	☐ Increased Stress	☐ Seizures/Epilepsy
☐ Difficulty concentrati	☐ Irritable	☐ Tiredness/fatigue
☐ Difficulty eating	☐ Learning disabilities	☐ Tingling in face
☐ Difficulty sleeping	☐ Muscle spasms	☐ Vertigo or dizziness

Others

Any history of (Check all that apply)		☐ None
☐ Anxiety	☐ Fibromyalgia	☐ Lupus
☐ Anemia	☐ Head or spinal injury	☐ Lyme
☐ Asthma	☐ Heartburn	☐ Meningitis
☐ Back Pain	☐ Heart problems	☐ Pelvic pain
☐ Bladder infection	☐ Herpes 1/2	☐ Shortness of breath
☐ Depression	☐ High cholesterol	☐ Sleep apnea
☐ Diabetes	☐ HIV	☐ Snoring
☐ Dislocates or loose joints	☐ Hypermobility	☐ Stomach issues/ulcer
☐ Eating disorder	☐ Kidney problems	☐ Tongue Tie

☐ Smoking/Tobacco U How often?

☐ Cancer If so what kind? When? Treatment?

Please let your therapist know if there is any other information that you feel is important for us to know.

☐ **I have complete all information above & agree that all I have provided is truthful and accurate.**

Patient Signature/Electronic Signature Date

Patient Agreement

Consent for Treatment: I have a condition requiring physical therapy intervention, and consent to the delivery of such care. In order to improve my physical condition in regards to pain, range of motion, strength or another type of physical impairment, I consent to commence the office of The Craniofacial and TMJ Institute program for evaluation and treatment. I request and authorize the licensed staff of The Craniofacial and TMJ Institute to render treatment and to perform appropriate procedures that my provider may deem reasonable and necessary for my diagnosis. I understand that my physical therapy care and treatment will be provided by a doctor of physical therapy. I am aware that there are certain risks involved with a physical therapy program. These risks include but are not limited to; exacerbation of current condition, organ puncture, dermal and sub-dermal burns, pneumothorax, hematoma, fractures, joint damage, nose bleeds, stroke or even death in the most rarest of cases. Every effort is made to minimize my risk by continuous assessment of my condition throughout my therapy. I will inform my doctor of physical therapy of any changes in my medical condition, or medications, as they may necessitate change in my therapy program.

I will stop any procedure or activity and inform my therapist of any symptoms of pain, fatigue, shortness of breath, rapid heart rate, dizziness or nausea that may develop during my treatment.

☐ (initials)

Privacy Notice Acknowledgement: I understand that The Craniofacial and TMJ Institute will maintain my privacy to the highest standards and may use or disclose my health information for the sole purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment and/or payment.

☐ (initials)

Terms and Conditions

Appointments/Cancellations: The Craniofacial and TMJ Institute ***requires 24 hours notification of cancellations.*** In the event I cancel a regularly scheduled appointment with less than 24 hours notice or I am not present or available for a scheduled appointment I will incur a full session fee. If there are 3 consecutive lapses in scheduled attendance I may be removed from the therapist's schedule & will have terminated this agreement.

Insurance: I understand that The Craniofacial and TMJ Institute is a fee for service physical therapy provider and The Craniofacial and TMJ Institute will **not** bill my insurance company directly. Further, I understand that I am responsible for asking for an itemized receipt from The Craniofacial and TMJ Institute which I may provide to my insurance company, if I have insurance. I understand that I am considered a ***self pay patient*** and I am financially responsible for the total amount of the services provided. The Craniofacial and TMJ Institute does not verify insurance coverage prior to providing services and does not guarantee reimbursement for services from my insurance company.

Payment: I understand that I am considered a ***self pay patient*** and am responsible for payment at the time of service. Billing will appear on my credit card or debit under the name of TMJ Institute or Bluegrass Doctors PT.

Attire: For access to particular body parts being treated, loose fitting clothing is recommended. If your evaluation includes a diagnosis that involves an assessment of the lumbar spine and or pelvis, this may require you to change clothing and wear a gown.

Adult Supervision: Those under the age of 17 receiving treatment by The Craniofacial and TMJ Institute must be accompanied by a parent or legal guardian during each physical therapy appointment.

Other Information: I understand I may also be charged for therapy products, educational materials and for other administrative expenses, including copies of medical
records, & that I will be notified of these charges at the time of service.

PATIENT'S SIGNATURE
This agreement must be signed by The Craniofacial and TMJ Institute patient/client unless the patient/client is a minor, incompetent, or physically incapable of signing. I have read and fully understand the content of this two-page Patient Agreement and hereby agree to and authorize the foregoing provisions.

As used in this document, the terms "I', "me" and "my" refer to and include, in addition to the undersigned, the patient/client named above and others for whom the undersigned is responsible or for whom the undersigned has assumed responsibility in engaging The Craniofacial and TMJ Institute to provide services to the patient/client.

By signing this agreement, I acknowledge that I have read all information above; Consent for treatment, privacy notice acknowledgment, and terms and condition. I understand, and AGREE to the above.

☐ **Yes I agree to Consent for treatment, privacy notice knowledgement, and terms and conditions**

Electronic Signature _____ Date _____

If signing for Minor or as a guardian please type your relationship here: _____

☐ **Does NOT apply to me**

PLEASE KEEP WITH ALL PAPERWORK.

ONLY COMPLETE THE FOLLOWING IF THIS APPLIES TO YOU

MEDICARE/MEDICAID OPT-OUT

I, _____, wish to be treated for my physical therapy diagnosis by The Craniofacial and TMJ Institute, and **under my own free** will have **chosen to pay** for treatment services rendered by the Provider by means of **my own private funds**, and agree with Provider that no claims to Medicare/Medicaid or my current secondary insurance carrier will be made.

I acknowledge that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the services I receive with the provider.

_____ (initials)

I acknowledge that I have a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from a Provider who has not opted-out of Medicare.

_____ (initials)

I understand that Medicare payment will not be made for any items or services furnished by the Provider that would have otherwise been covered by Medicare if there were no private contract.

_____ (initials)

As used in the document the term provider is in relation to The Craniofacial and TMJ Institute and its affiliates. The terms "I', "me" and "my" refer to and include, in addition to the undersigned, the patient/client named above and others for whom the undersigned is responsible or for whom the undersigned has assumed responsibility in engaging The Craniofacial and TMJ Institute to provide services to the patient/client.

☐ **I state that to the best of my knowledge this statement is correct and true.**

☐ **I understand CTI does NOT work with/able to provide receipts for Medicare/Medicaid**

Electronic Signature _____ Date _____