The Craniofacial and TMJ Institute
(Bluegrass Doctors of Physical Therapy, PLLC)

____
Patient Name

Patient Contact Information

Today's Date____________________________

Patient Name____

DOB__________________________

Address____

City_______________________________________ State_________________ Zip Code______________

Gender______________ Marital Status______________

Occupation________________________

Home Phone_____________________ Cell Phone _____________________ Work Phone__________________

Preferred number for contacting:

☐ Home ☐ Work ☐ Cell

Email____

Employer____

Work Phone ____________________________

Work Address_________________________________

City___________________ State_________________ Zip Code______________

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

Name____

Address____

City______________________________________State_________________ Zip Code______________

Home Phone______________________ Cell Phone _____________________

Emergency Information/ Nearest Relative

☐ **Same as above**

Name___________________________________Relationship_______________

Address___________________________________ City________________________ State_____________

Zip Code___________

Home Phone_____________________ Cell Phone _____________________

Work Phone _____________________

☐ Medical information can be shared with this person.

Physician Information

Name____

Address___________________________________ City________________________ State_____________

Zip Code___________

Phone Number______________________________

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 (if referred from a physician).

____ __________________________

Patient Signature Date

Confidential Information

The Craniofacial and TMJ Institute
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____
Patient Name

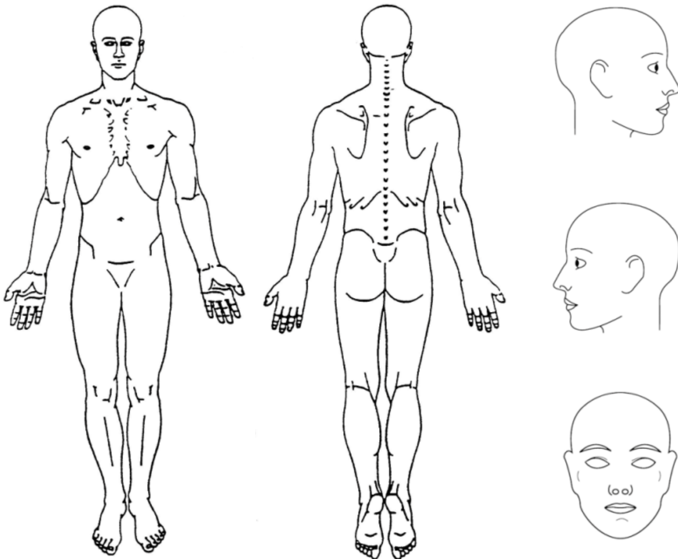
Patient Questionnaire

From whom did you hear about us?______________________________

History of current condition: (Please describe location, intensity, duration, and onset of condition. (Use back of form if needed and diagram and questions below)

____
____
____

Please indicate the areas you are having pain.
You may shade, color or simply mark the areas.



Please rate the intensity of your pain at its worse below:
0-1-2-3-4-5-6-7-8-9-10
(no pain) (Worst Imaginable)

What has made your pain worse?
____
____
____
____

Please rate the intensity of your pain at its best below:
0-1-2-3-4-5-6-7-8-9-10
(no pain) (Worst Imaginable)

What has made your pain better?
____
____
____
____

HEADACHE HISTORY:

Do you have headaches?
☐ Yes ☐ No

Are they recurrent: How often?______________________________

Are there any triggers? ______________________________

Have you missed work or school?

☐ Yes How often?______________________________
☐ No

Does the pain radiant or stay in place?______________________________

____
Patient Name

How long does it last? ____________________

Does your headache cause you to vomit?

☐ Yes ☐ No

Have you been knocked unconscious?

How many times? ____________________

When? ____________________

DENTAL/FACIAL HISTORY:

Who is your dentist?____________________

Please check all that apply:

☐ Braces: If so, When:__________

☐ Night splint/retainer

☐ Grind or clench teeth

☐ Recurrent sinus infections

☐ TMJ Pain/Dysfunction

☐ Popping or clicking in jaw

☐ Jaw locked

☐ Recurrent ear infections

☐ Pre-mature closure of cranial sutures

☐ Palate Expander

☐ Biting Finger nails

☐ Chewing on objects or lips, cheeks, tongue

☐ Wisdom teeth removed: How many and when?

____

When you have pain, where is it predominantly?

☐ Eye
☐ Cheek
☐ Nose
☐ Upper jaw
☐ Lower Jaw
☐ Teeth
☐ Throat
☐ Tongue
☐ Tonsils
☐ Lips
☐ Other:____________________

Do you remember when and where your facial pain started?

☐ Yes ____________________

☐ No

Did you have a trauma or stressful event surrounding the onset of the pain?

☐ Yes____________________

____

☐ No

Was the pain gradual or sudden?

☐ Gradual ☐ Sudden

Is the pain consistent or intermittent?

☐ Consistent

☐ Intermittent - Please describe the frequency? ____________________

____

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Patient Name

Is the pain consistently felt in the same area?

☐ Yes
☐ No How does it move or change? ______________________

____

Does the pain feel superficial, on the skin, or deep "in the bone?"

☐ Superficial ☐ Deep

Do you have pain just on one side of your face?

☐ Yes which side: ☐ No
- ☐ left
- ☐ right

When you have pain, is it predominantly deep in your ear?

☐ Yes ☐ No

Type of sensations

☐ Electrical	☐ Stabbing	☐ Numbness
☐ Shocking	☐ Shooting	☐ Twitching
☐ Dull	☐ Burning	☐ Tingling

Can your pain start by something touching your face (for example, by eating, washing your face, shaving, brushing teeth, 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)

____

____

☐ None

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 <u>that has not been done</u>? When and what?

____

____

☐ None

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Please list all previous injuries, accidents, surgeries and any other pertinent medical information.
(Please include dates and type of surgery.)

____
____
____
____

☐ None

Please list ***all*** medical conditions and/or health concerns.

____
____

☐ None

Please list ***all*** current medications.

____
____
____

☐ 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, teeth, or joint replacements)

____
____

☐ None

Have you been:

☐ Knocked unconscious: How many times?______________________________
When?______________________________________

☐ Scuba diving
- ☐ Yes. How often?__________________________________
  How deep?__________________________________
- ☐ No

☐ Flown in a plane more than 15 times in a year

☐ Motor Vehicle accident. How many and when?______________________________________

Do you or have you ridden:

☐ Horses
☐ ATV's
☐ Tubing
☐ Motorcycles
☐ Mountain bikes
☐ Skiing: water or snow

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Do you now have or have you had any of these symptoms in the past year? (Check all that apply)

- ☐ Change in bowel movements
- ☐ Persistent joint pain
- ☐ Irritable bowel
- ☐ Blood in bowel/urine
- ☐ Hot flashes
- ☐ Vertigo or dizziness
- ☐ Persistent nose bleeds
- ☐ Difficulty concentrating
- ☐ Learning disabilities
- ☐ Tiredness/fatigue
- ☐ Muscle spasms
- ☐ Fainting spells
- ☐ Eating disorder/difficulty eating
- ☐ Difficulty sleeping
- ☐ Seizures/Epilepsy
- ☐ Osteoporosis/Osteopenia
- ☐ Anxiety
- ☐ Depression
- ☐ Other____________________________

Any history of: (check all that apply)

- ☐ None
- ☐ Kidney Problems
- ☐ Dislocations or loose joints
- ☐ Head or spinal injuries
- ☐ Meningitis
- ☐ Stomach ulcers
- ☐ Heartburn/indigestion
- ☐ Shortness of breath
- ☐ Anemia
- ☐ Asthma
- ☐ Bladder infection
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Depression
- ☐ Pelvic pain
- ☐ Sleep Apnea
- ☐ Snoring

- ☐ Smoking/Tobacco products: How much?____
- ☐ Cancer? If so what kind? When?

____

____

- ☐ Other____

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

____

____

____

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________ Not sure________

____ __________________________
Patient Signature Date

____
For office use: