



**TMJ & Sleep
Therapy Centre**

PATIENT HEALTH QUESTIONNAIRE

Today's Date: _____

Demographic Information

Last Name: _____ Middle Initial: _____ First Name: _____

Single Married Widowed Separated Divorced

Age: _____ Date of Birth: _____ SSN: _____ Sex: Male Female

Ethnicity: American Indian/Alaska Native Asian Black/African American Hispanic/Latino
 Native Hawaiian/Pacific Islander White Other Decline

Occupation: _____

Responsible Party/Legal Guardian (if different than patient): _____ Relationship to Patient: _____

Contact Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referral Information - how did you hear about us?

Referral Name/Source: _____

Referral Type: Doctor Dentist Specialist Patient Other _____

Provider Information

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

I authorize communications and consent to release and/or obtain any of my information regarding my treatment with Daniel G. Klauer, DDS including a full report of examination findings, diagnosis, treatment plan and progress report between TMJ & Sleep Therapy Centre and the professional care team listed above.

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

I authorize communications and consent to release and/or obtain any of my information regarding my treatment with Daniel G. Klauer, DDS including a full report of examination findings, diagnosis, treatment plan and progress report between TMJ & Sleep Therapy Centre and the professional care team listed above.

Additional Provider Office (if applicable): _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

I authorize communications and consent to release and/or obtain any of my information regarding my treatment with Daniel G. Klauer, DDS including a full report of examination findings, diagnosis, treatment plan and progress report between TMJ & Sleep Therapy Centre and the professional care team listed above.

Additional Provider Office (if applicable): _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

I authorize communications and consent to release and/or obtain any of my information regarding my treatment with Daniel G. Klauer, DDS including a full report of examination findings, diagnosis, treatment plan and progress report between TMJ & Sleep Therapy Centre and the professional care team listed above.

Patient Initials: _____



Current Symptoms

Reason(s) for this appointment: Pain Sleep/Airway Orthodontics Other _____

Please number your chief complaint as 1 and all other complaints starting at 2 and increasing numerically:

- | | | |
|---|--|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Tossing & Turning |
| <input type="checkbox"/> Difficulty Closing Mouth | <input type="checkbox"/> Nerve Pain | <input type="checkbox"/> Kicking/Jerking Legs Repeatedly |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Morning Headaches |
| <input type="checkbox"/> Dyskinesia | <input type="checkbox"/> Pain When Chewing | <input type="checkbox"/> Morning Hoarseness in Voice |
| <input type="checkbox"/> Ear Congestion | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Nighttime Choking Spells |
| <input type="checkbox"/> Ear Stuffiness | <input type="checkbox"/> Throat Pain | <input type="checkbox"/> Nighttime Urination |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Tinnitus (Ringing in Ears) | <input type="checkbox"/> Repeated Awakening |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Short of Breath |
| <input type="checkbox"/> Headache (inside head) | <input type="checkbox"/> Acid Indigestion | <input type="checkbox"/> Sore Jaw Upon Waking |
| <input type="checkbox"/> Headache (outside head) | <input type="checkbox"/> Affecting Sleep Partner | <input type="checkbox"/> Swelling in Ankles/Feet |
| <input type="checkbox"/> Jaw Joint Locking | <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Teeth Crowding |
| <input type="checkbox"/> Jaw Joint Noises | <input type="checkbox"/> Dry Mouth Upon Waking | <input type="checkbox"/> Teeth Grinding |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Told I Stop Breathing During Sleep |
| <input type="checkbox"/> Limited Ability to Open | <input type="checkbox"/> Feel Unrefreshed in Morning | <input type="checkbox"/> Unable to Tolerate CPAP |
| <input type="checkbox"/> Muscle Twitching | <input type="checkbox"/> Frequent Heavy Snoring | <input type="checkbox"/> Vivid Dreams |

What is your level of head, neck, and facial pain? 0 = no pain to 10 = worst possible pain

Currently: _____ At its best: _____ At its worst: _____

What results are you seeking from treatment? _____

Please check any dental symptoms that you are currently experiencing:

- | | | |
|--|--|--|
| <input type="checkbox"/> Changes in bite | <input type="checkbox"/> Teeth Crowding | <input type="checkbox"/> Teeth Spacing |
| <input type="checkbox"/> Dental Changes | <input type="checkbox"/> Teeth Sensitivity | <input type="checkbox"/> None |

Any symptoms not listed above? _____

- In which position do you sleep? back side stomach varies
- Where do you sleep? bed chair couch other
- Do you have a bed partner? yes no
- Is it easy for you to fall asleep? yes no
- How many times do you wake during the night? _____
- Do you feel rested upon waking? yes no
- Has anyone ever told you that you stop breathing during sleep? yes no
- Have you ever had a sleep study? yes no If yes: Date: _____ Location: _____

Patient Initials: _____



Medications

Please list all medications you are currently taking and the reason you are taking them. Include prescription, over the counter, vitamins, herbs, etc. (Please attach additional sheet if necessary)

Medication	Dosage	Reason for Taking

Previous treatments/medications for the condition we are evaluating:

Treatment/Medication	Doctor/Provider	Approximate Date of Treatment

TMJ & Sleep Therapy Centre has my permission to obtain my complete medication history, including electronic prescription submission

Allergies

Please check any and all medications or substances that have caused an allergic reaction:

- | | | |
|---------------------------------------|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Iodine | <input type="checkbox"/> Plastic |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Metals | <input type="checkbox"/> Sulfa |

Other: _____

Medical History

Have you had prior orthodontic treatment? yes no

Have you had sustained injury to: head face neck teeth

Other: _____

Please indicate if you have had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> General Anesthesia | <input type="checkbox"/> Jaw Joint Surgery | <input type="checkbox"/> Removal of Wisdom Teeth |
| <input type="checkbox"/> Adenoids Removed | <input type="checkbox"/> Orthognathic Surgery | <input type="checkbox"/> Nasal Surgery |
| <input type="checkbox"/> Tonsils Removed | <input type="checkbox"/> Oral Surgery | |

Other Surgeries: _____

Do you have trouble breathing through your nose? yes no

Are you currently pregnant? yes no

Do you drink 4 or more cups of coffee per day? yes no

Do you smoke tobacco? yes no

Do you consume alcohol? yes no if yes: habitually socially

Do you take any sedatives/medications/supplements to help yourself fall asleep at night? yes no

If yes, what: _____

Patient Initials: _____



Medical History, Continued

Have you ever experienced: Physical Abuse Verbal Abuse Emotional Abuse Sexual Abuse None
(Optional - check applicable)

If yes, please explain (optional): _____

Do you have or have you experienced any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nervous System Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Neuralgia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Disorder/Heart Attack | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Ovarian Cyst |
| <input type="checkbox"/> Bleeding Easily | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Bruising Easily | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Postural Orthostatic Tachycardia Syndrome (POTS) |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Cold Hands and Feet | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Weight Gain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> History of Substance Abuse | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Huntington's Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Difficulty Breathing at Night | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatoid Fever |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Intestinal Disorder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Ehlers-Danlos Syndrome (EDS) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Significant Daytime Drowsiness |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Slow Healing Sores |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Speech Difficulties |
| <input type="checkbox"/> Fluid Retention | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Frequent Awakening at Night | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swollen, Stiff, or Painful Joints |
| <input type="checkbox"/> Frequent Colds/Flus | <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Tired Muscles |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Muscle Fatigue | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Frequent Sore Throat | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Urinary Tract Disorder |
| <input type="checkbox"/> Gastroesophageal Reflux (GERD) | <input type="checkbox"/> Muscle Tremors | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | |

Does your family have a history of similar conditions, symptoms, or diseases? yes no If yes, who: _____

- Have you been prescribed a CPAP? yes no Do you use it as prescribed? yes no
- Have you had a previous oral appliance, mouthguard, splint, retainer? yes no Do you use it as prescribed? yes no
- How many hours of sleep, on average, do you get per night? _____
- How many hours of sleep, on average, during the day? _____
- Do you ever cough, gasp, or snort upon waking? yes no

Patient Initials: _____



Currently Experiencing

Are you currently experiencing head pain? yes no

If yes, please indicate all that apply:

	Location			Time Frame		Severity			Duration			Frequency		
	Left	Right	Bilateral	Recent	Chronic (over 6 mo.)	Mild	Moderate	Severe	Min.	Hrs.	Days	Occasional	Frequent	Constant
Temple Area (Temporal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back of Head (Occipital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forehead (Frontal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Top of Head (Parietal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Head Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently experiencing jaw conditions? yes no

If yes, please indicate all that apply:

Jaw pain with opening	<input type="checkbox"/> left	<input type="checkbox"/> right
Jaw pain when chewing	<input type="checkbox"/> left	<input type="checkbox"/> right
Jaw pain at rest	<input type="checkbox"/> left	<input type="checkbox"/> right
Jaw sounds with opening	<input type="checkbox"/> left	<input type="checkbox"/> right
Jaw sounds when chewing	<input type="checkbox"/> left	<input type="checkbox"/> right
Jaw sounds at rest	<input type="checkbox"/> left	<input type="checkbox"/> right

Please indicate if you have had any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Jaw Locks Closed | <input type="checkbox"/> Nighttime Clenching/Grinding | <input type="checkbox"/> Pain/Pressure behind eyes |
| <input type="checkbox"/> Jaw Locks Open | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Extreme Sensitivity to light |
| <input type="checkbox"/> Daytime Teeth Clenching/Grinding | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Wear Glasses or Contact Lenses |

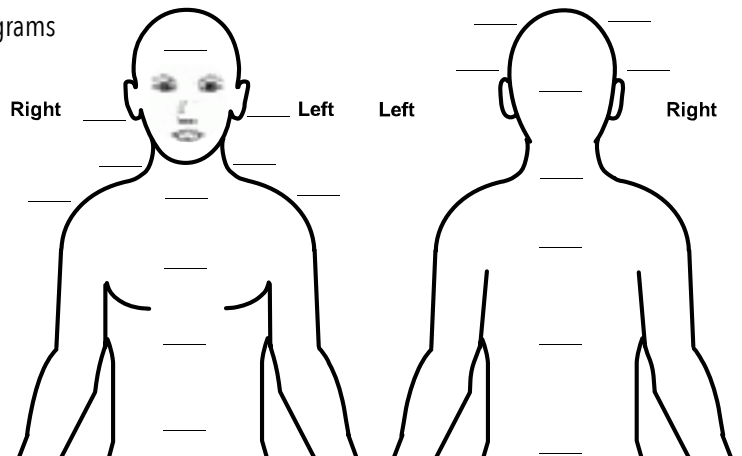
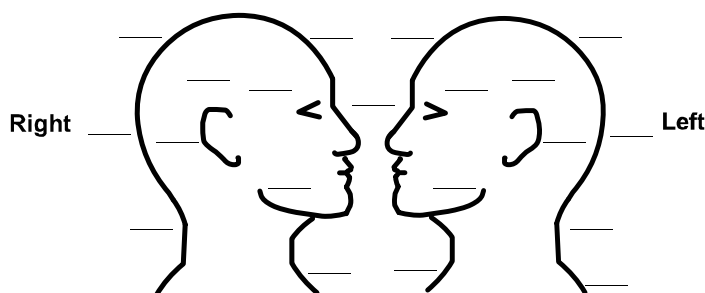
Are you currently experiencing any ear related conditions? yes no

If yes, please indicate all that apply:

Ear Congestion	<input type="checkbox"/> left	<input type="checkbox"/> right
Ear Pain	<input type="checkbox"/> left	<input type="checkbox"/> right
Hearing Loss	<input type="checkbox"/> left	<input type="checkbox"/> right
Itchiness or Stuffiness in Ears	<input type="checkbox"/> left	<input type="checkbox"/> right
Pain Behind the Ear	<input type="checkbox"/> left	<input type="checkbox"/> right
Pain in Front of the Ear	<input type="checkbox"/> left	<input type="checkbox"/> right
Recurrent Ear Infections	<input type="checkbox"/> left	<input type="checkbox"/> right
Ringing in the Ear	<input type="checkbox"/> left	<input type="checkbox"/> right

Please indicate your areas of pain by labeling the body and head diagrams with the appropriate numbers below.

1 - Mild Pain 2 - Moderate Pain 3 - Severe Pain



Patient Initials: _____



TMJ & Sleep Therapy Centre

1245 E. University Drive
Granger, IN 46530

Please indicate if you have had any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Chronic Sore Throat | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Middle Back Pain |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Numbness in hands/fingers | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Swollen Gland | <input type="checkbox"/> Swelling in the neck | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Thyroid Enlargement | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Chronic Sinusitis |
| <input type="checkbox"/> Tightness in Throat | <input type="checkbox"/> Shoulder Stiffness | <input type="checkbox"/> Broken Teeth |
| <input type="checkbox"/> Constant Feeling of Foreign Object in Throat | <input type="checkbox"/> Tingling in hands or fingers | <input type="checkbox"/> Dry Mouth |
| <input type="checkbox"/> Limited Movement of Neck | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Frequent Biting of the Cheek |
| | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Burning Tongue Sensation |

Symptom History

On what date, or approximate date, did your condition/symptoms first occur? _____

Can you relate your pain/condition to a motor vehicle accident or traumatic injury? yes no

If yes, please explain: _____

Does any family member have a sleep breathing disorder or Obstructive Sleep Apnea? yes no

If yes, who: _____

Does any family member have the same or a similar problem? yes no

If yes, please explain: _____

Additional Information

Is there anything else you would like us to know?

Emergency Contact Information

In case of an emergency, please contact:

Name: _____ Phone: _____ Relationship: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

The person(s) listed have my approval to access my information:

Name: _____ Relationship: _____ Medical Information Financial Information

Name: _____ Relationship: _____ Medical Information Financial Information

Signature

I acknowledge that I have been offered a copy of the Office Privacy Notice and I am familiar with my rights as a patient of Dr. Klauer and TMJ & Sleep Therapy Centre

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

My signature above certifies that the information listed on this form is accurate and complete to the best of my knowledge.