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: _____

For Office Use Only - Date of Completion: _____

TMJ & Sleep Therapy Centre
1245 E. University Drive
Granger, IN 46530

Current Symptoms

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

Please check all symptoms you are currently experiencing, then number your top 5 chief complaints starting with your most bothersome symptom:

____Back Pain
____Difficulty Closing Mouth
____Dizziness
____Dyskinesia
____Ear Congestion
____Ear Pain
____Ear Stuffiness
____Eye Pain
____Facial Pain
____Headache (inside head)
____Headache (outside head)
____Jaw Joint Locking
____Jaw Joint Noises
____Jaw Pain
____Limited Ability to Open
____Muscle Twitching
____Neck Pain
____Nerve Pain
____Numbness
____Pain When Chewing
____Shoulder Pain
____Sinus Congestion
____Throat Pain
____Tinnitus (Ringing in Ears)
____Vision Problems
____Acid Indigestion
____Affecting Sleep Partner
____Difficulty Falling Asleep
____Dry Mouth Upon Waking
____Fatigue
____Feel Unrefreshed in Morning
____Frequent Heavy Snoring
____Frequent Tossing & Turning
____Kicking/Jerking Legs Repeatedly
____Morning Headaches
____Morning Hoarseness in Voice
____Night Sweats
____Nighttime Choking Spells
____Nighttime Urination
____Repeated Awakening
____Short of Breath
____Sore Jaw Upon Waking
____Swelling in Ankles/Feet
____Teeth Crowding
____Teeth Grinding
____Told I Stop Breathing During Sleep
____Unable to Tolerate CPAP
____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:

____Changes in bite
____Dental Changes
____Teeth Crowding
____Teeth Sensitivity
____Teeth Spacing
____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: _____

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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:

____Anesthetics
____Antibiotics
____Aspirin
____Barbiturates
____Codeine
____Iodine
____Latex
____Metals
____Penicillin
____Plastic
____Sedatives
____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:

____General Anesthesia
____Adenoids Removed
____Tonsils Removed
____Jaw Joint Surgery
____Orthognathic Surgery
____Oral Surgery
____Removal of Wisdom Teeth
____Nasal 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: _____

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Medical History, Continued

Have you ever experienced:
(Optional - check applicable)

____Physical Abuse ____Verbal Abuse ____Emotional Abuse ____Sexual Abuse ____None

If yes, please explain (optional): _____

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

____AIDS/HIV
____Anemia
____Anxiety
____Asthma
____Birth Defects
____Bleeding Easily
____Bruising Easily
____Cancer
____Chronic Fatigue
____Cold Hands and Feet
____Depression
____Diabetes
____Difficulty Breathing at Night
____Difficulty Concentrating
____Dizziness
____Eating Disorder
____Ehlers-Danlos Syndrome (EDS)
____Emphysema
____Epilepsy
____Excessive Thirst
____Fainting
____Fibromyalgia
____Fluid Retention
____Frequent Awakening at Night
____Frequent Colds/Flus
____Frequent Cough
____Frequent Ear Infections
____Frequent Sore Throat
____Gastroesophageal Reflux (GERD)
____Glaucoma
____Hay Fever
____Hearing Impairment
____Heart Disorder/Heart Attack
____Heart Murmur
____Heart Pacemaker
____Heart Palpitations
____Heart Valve Replacement
____Hemophilia
____Hepatitis
____High Blood Pressure
____History of Substance Abuse
____Huntington's Disease
____Hypoglycemia
____Insomnia
____Intestinal Disorder
____Irregular Heartbeat
____Kidney Disease
____Leukemia
____Liver Disease
____Low Blood Pressure
____Memory Loss
____Meniere's Disease
____Migraines
____Mitral Valve Prolapse
____Muscle Aches
____Muscular Dystrophy
____Muscle Fatigue
____Muscle Spasms
____Muscle Tremors
____Multiple Sclerosis
____Nervous System Disorder
____Neuralgia
____Osteoarthritis
____Osteoporosis
____Ovarian Cyst
____Parkinson's Disease
____Poor Circulation
____Postural Orthostatic Tachycardia Syndrome (POTS)
____Psychiatric Care
____Recent Weight Gain
____Recent Weight Loss
____Rheumatoid Arthritis
____Rheumatoid Fever
____Scarlet Fever
____ Seizures
____Shortness of Breath
____Significant Daytime Drowsiness
____Sinus Problems
____Skin Disorder
____Slow Healing Sores
____Sleep Apnea
____Speech Difficulties
____Stroke
____Swollen, Stiff, or Painful Joints
____Thyroid Problem
____Tired Muscles
____Tuberculosis
____Urinary Tract Disorder

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

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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)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Back of Head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Forehead (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Top of Head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
General Head Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Are you currently experiencing jaw conditions? ☐ yes ☐ no

If yes, please indicate all that apply:

Jaw pain with opening	☐ left	☐ right
Jaw pain when chewing	☐ left	☐ right
Jaw pain at rest	☐ left	☐ right
Jaw sounds with opening	☐ left	☐ right
Jaw sounds when chewing	☐ left	☐ right
Jaw sounds at rest	☐ left	☐ right

Please indicate if you have had any of the following:

____Jaw Locks Closed
____Jaw Locks Open
____Daytime Teeth Clenching/Grinding
____Nighttime Clenching/Grinding
____Blurred Vision
____Double Vision
____Pain/Pressure behind eyes
____Extreme Sensitivity to light
____Wear Glasses or Contact Lenses

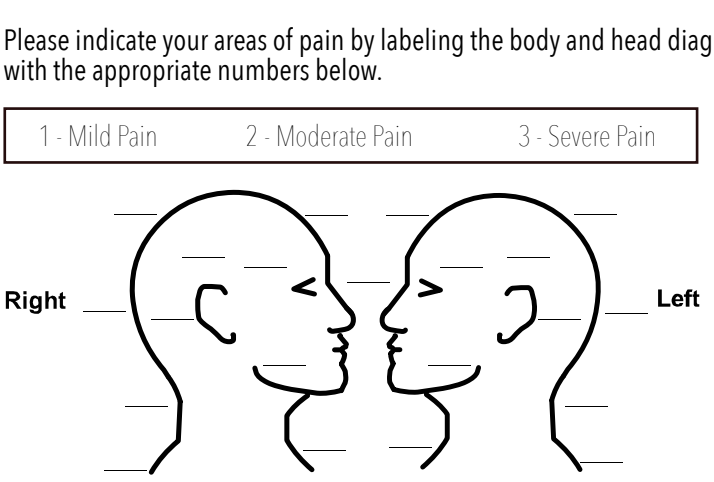
Are you currently experiencing any ear related conditions? ☐ yes ☐ no

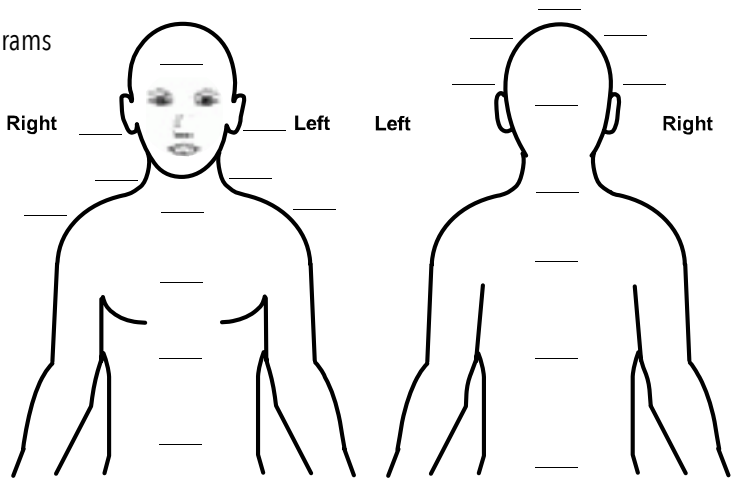
If yes, please indicate all that apply:

Ear Congestion	☐ left	☐ right
Ear Pain	☐ left	☐ right
Hearing Loss	☐ left	☐ right
Itchiness or Stuffiness in Ears	☐ left	☐ right
Pain Behind the Ear	☐ left	☐ right
Pain in Front of the Ear	☐ left	☐ right
Recurrent Ear Infections	☐ left	☐ right
Ringing in the Ear	☐ left	☐ 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





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Please indicate if you have had any of the following:

____Chronic Sore Throat	____Neck Pain	____Middle Back Pain
____Difficulty Swallowing	____Numbness in hands/fingers	____Scoliosis
____Swollen Gland	____Swelling in the neck	____Sciatica
____Thyroid Enlargement	____Shoulder Pain	____Chronic Sinusitis
____Tightness in Throat	____Shoulder Stiffness	____Broken Teeth
____Constant Feeling of Foreign Object in Throat	____Tingling in hands or fingers	____Dry Mouth
	____Lower Back Pain	____Frequent Biting of the Cheek
____Limited Movement of Neck	____Upper Back Pain	____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. I understand this practice is Fee for Service Out-of-Network and regardless of my insurance coverage, I am responsible for any charges incurred at the time of my visit.

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.