



- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Are you currently taking any medication?<br>What? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you allergic to any food or medicine?<br>What? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had orthodontic treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had periodontal disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been treated for a "bad bite"?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been treated for problems or discomfort with your<br>jaw joint, or facial muscles? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you ever awaken with soreness of your teeth or jaws?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you clench or grind your teeth during the day?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told that you grind your teeth while sleeping?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth sensitive when chewing?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have tension or migraine headaches?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you frequently have neckaches or stiff neck muscles?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your jaw muscles become tired frequently?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have difficulty in opening your mouth widely?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have difficulty in swallowing?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had arthritis?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever received a severe blow to the side of the head or jaw?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had problems with your ears,<br>such as ringing or change of hearing?              | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you ever hear clicking or popping sounds from your jaw joint?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you presently in any pain from your jaw joint or muscles?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Does pain or discomfort from your jaw joint interfere<br>with your work or other activities?     | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there times when you notice that this problem or pain<br>is less or gone completely?         | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel you need treatment for this problem?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a problem with insomnia?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take aspirin frequently?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any other information you feel we should know?  | <input type="checkbox"/> | <input type="checkbox"/> |

What is your chief concern?  
Please explain. \_\_\_\_\_  
\_\_\_\_\_

REFERRED TO THIS OFFICE BY: \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_