HEAD HEALTH HISTORY

PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

#	DENTAL FOUNDATION (TEETH, MUSCLES, JOINTS)		
1	Have you noticed a change in the way your teeth fit together? » If 'Yes', it is because of ☐ Dental Changes ☐ Trauma ☐ Other	☐ Yes	☐ No
2	Where do you think your teeth hit or fit first? » More on the: ☐ Left ☐ Right ☐ Equal » More on the: ☐ Front ☐ Back ☐ Equal		
3	Do your jaw muscles get tight or sore? » When? ☐ Morning ☐ Evening ☐ After chewing	☐ Yes	☐ No
4	Do you have pain or difficulty opening wide?	☐ Yes	☐ No
5	Are you aware of noises in your jaw joints? ☐ Popping ☐ Clicking ☐ Other » Where? ☐ Right ☐ Left ☐ Both » How long? ☐ Less than 1 year ☐ More than 1 year	☐ Yes	☐ No

#	SYMPTOMS
13	Do you experience pain in » Jaw ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Face ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Neck ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Shoulders ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Arms ☐ Right ☐ Left ☐ Both ☐ More than 1 year
14	Do you experience ringing or fullness in your ears? ☐ Yes ☐ No » Which one? ☐ Right ☐ Left ☐ Both
15	How often do you get headaches that make it difficult to function without medication? ☐ Almost Daily ☐ More than once a week ☐ More than once a month ☐ Almost never
16	How often do you get other milder headaches? ☐ Almost Daily ☐ More than once a week ☐ More than once a month ☐ Almost never
17	Have your headaches changed in the last six months? ☐ About the same ☐ Slight worsening ☐ Same but more frequent ☐ Somewhat less ☐ A lot worse Got less/worse when _____

	CAUSES & COMPLICATIONS		
6	Do you grind or clench your teeth? » Do you wear a? ☐ Splint ☐ Night Guard ☐ Retainer ☐ NTI ☐ Sleep Appliance	☐ Yes	☐ No
7	Have you had any significant dental treatments? ☐ Orthodontics ☐ Oral surgery / wisdom teeth removal ☐ Long dental appointments ☐ Tooth Loss ☐ Crowns	☐ Yes	☐ No
8	Have you been in a motor vehicle accident, major or minor? » How many? _____ » When was the last accident? ☐ 0-3 Months ☐ 3-12 Months ☐ More than 1 year » Did you hit your head? ☐ Head Injury ☐ Whiplash ☐ Concussion ☐ Car ☐ ATV ☐ Motorcycle ☐ Bicycle ☐ Other _____	☐ Yes	☐ No
9	Have you had other head/neck trauma? ☐ Slip/Fall ☐ Sports Injury ☐ Trauma ☐ Fights/Domestic Violence ☐ Other » When? ☐ 0-3 Months ☐ 3-12 Months ☐ More than 1 year » Type of injury ☐ Head Injury ☐ Concussion ☐ Whiplash ☐ Neck Injury	☐ Yes	☐ No
10	Do you have any postural position problems? ☐ Working at a desk ☐ Sitting at work ☐ Computer/laptop ☐ Commuting	☐ Yes	☐ No
11	Daytime sleepiness, drowsiness, or tiredness?	☐ Yes	☐ No
12	Problems with sleep? » Insomnia ☐ Yes ☐ No » Sleep Apnea ☐ Yes ☐ No » Sleep Disturbances ☐ Yes ☐ No » Less than 7 hours per night ☐ Yes ☐ No » Other _____		

#	IMPACT ON DAILY LIVING ACTIVITIES
18	What is your stress level? ☐ Mild ☐ Moderate ☐ Severe
19	What is your anxiety level? ☐ Mild ☐ Moderate ☐ Severe
20	What have you missed out upon because of your pain or headaches? *(Check all that apply)* ☐ Days at work ☐ Focus at work ☐ Activities with friends/family ☐ Activities with children ☐ Household chores ☐ Major events
21	When you have pain, headaches or migraines, how does that make you feel? *(Check all that apply)* ☐ Angry ☐ Depressed ☐ Tired or exhausted ☐ Frustrated ☐ Guilty ☐ Ashamed ☐ Relationship tension ☐ Other _____
22	How many days per month are you: Pain Free? _____ Headache Free? _____
	NOTES: _____