PAIN AND SLEEP
Therapy Center

# ADULT 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 ☐ Other _____

Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African America ☐ 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: _____

**Primary Care Physician Office:** _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

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

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

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

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

For Office Use Only - Date of Completion: _____

Patient Initials: _____

## Current Symptoms

Reason(s) for this appointment: ☐ TMD / Pain ☐ Sleep / Airway ☐ Orthodontics ☐ Myofunctional Therapy

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

___Headache (inside head)
___Headache (outside head)
___Morning Headaches
___Facial Pain
___Jaw Pain
___Jaw Locking
___Jaw Joint Noises
___Limited Ability to Open Mouth
___Difficulty Closing Mouth
___Pain When Chewing
___Neck Pain
___Back Pain
___Ear Pain
___Tinnitus (Ringing in Ears)
___Ear Congestion/Stuffiness
___Difficulty Falling Asleep
___Fatigue
___Feeling Unrefreshed in Morning
___Snoring/Loud Breathing
___Told I Stop Breathing
___Nighttime Choking Spells
___Frequent Tossing & Turning
___Repeated Awakening
___Nighttime Urination
___Kicking/Jerking Legs
___Night Sweats
___Vivid Dreams
___Affecting Sleep Partner
___Shortness of Breath
___Throat Pain
___Acid Indigestion
___Eye Pain
___Vision Problems
___Nerve Pain
___Numbness
___Muscle Twitching
___Dizziness
___Sinus Congestion
___Dry Mouth Upon Wakening
___Sore Jaws Upon Wakening
___Morning Hoarseness in Voice
___Unable to Tolerate CPAP
___Teeth Grinding
___Prior Orthodontic Treatment

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 have or are currently experiencing:**

___Changes in bite ___Orthodontics ___Teeth Crowding ___Biting of Cheeks ___Teeth Spacing ___Broken Teeth
___Dental Changes ___Dentures ___Teeth Sensitivity ___Burning Mouth ___Dry Mouth ___Missing Teeth

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: _____ Ordering Provider: _____

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

## 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 |
|---|---|---|
| | | |
| | | |
| | | |

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

If yes, what:_____

☐ Pain & Sleep Therapy Center had my permission to obtain my complete medication history, including electronic submission.

## Allergies

Do you have any known allergies/sensitivities to medications or your environment? Please List:

_____

_____

_____

Other:_____

## Medical History

Have you had prior orthodontic/braces 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 ___Jaw Joint Surgery ___Removal of Wisdom Teeth

___Adenoids Removed ___Orthognathic Surgery ___Nasal Surgery

___Tonsils Removed ___Oral Surgery

Other Surgeries:_____

Do you have trouble breathing through your nose? ☐ yes ☐ no

Are you currently pregnant? ☐ yes ☐ no

Do you consume caffeine - if Yes, How Much? ☐ yes ☐ no ___How Much?

Do you smoke tobacco? ☐ yes ☐ no

Do you consume alcohol? ☐ yes ☐ no

if yes: ☐ habitually ☐ socially

## Medical History, Continued

**Please indicate if you have had any of the following:**

___Chronic Sore Throat
___Difficulty Swallowing
___Swollen Gland
___Thyroid Enlargement
___Tightness in Throat
___Constant Feeling of Foreign Object in Throat
___Limited Movement of Neck
___Neck Pain
___Numbness in hands/fingers
___Swelling in the neck
___Shoulder Pain
___Shoulder Stiffness
___Tingling in hands or fingers
___Lower Back Pain
___Upper Back Pain
___Middle Back Pain
___Scoliosis
___Sciatica
___Chronic Sinusitis
___Broken Teeth
___Dry Mouth
___Frequent Biting of the Cheek
___Burning Tongue Sensation

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

___AIDS/HIV
___Anemia
___Anxiety
___Asthma
___Birth Defects
___Bleeding Easily
___Bruising Easily
___Cancer
___Cholesterol (High/Low)
___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
___Mouth Breathing
___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
___Sciatica
___Scoliosis
___ Seizures
___Shortness of Breath
___Significant Daytime Drowsiness
___Sjogrens
___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
___Vision Problems

**Does your family have a history of similar conditions, symptoms, or diseases?** ☐ yes ☐ no ☐ Don't Know

If yes, who:_____

## 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/tension with opening | ☐ left | ☐ right |
| Jaw pain/tension when chewing | ☐ left | ☐ right |
| Jaw pain/tension 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

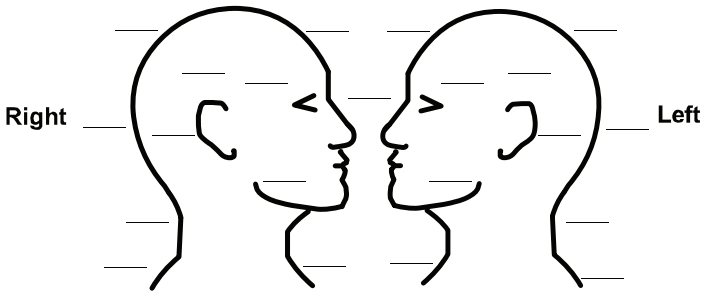
Are you currently experiencing any ear related conditions? ☐ yes ☐ no

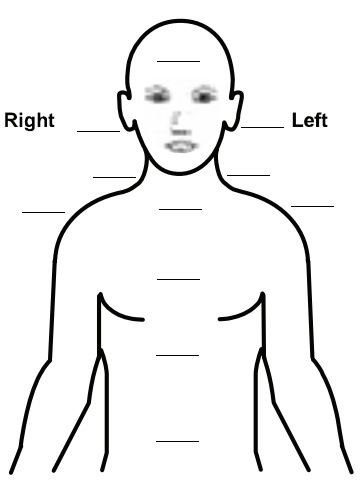
If yes, please indicate all that apply:

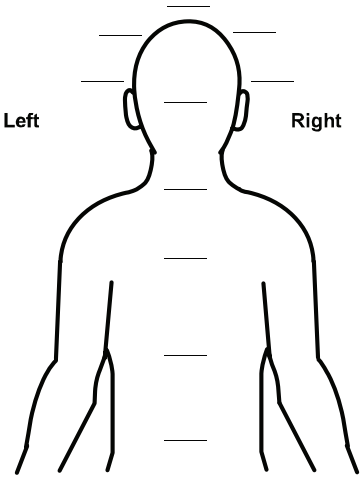
| | | |
|---|---|---|
| Ear Congestion | ☐ left | ☐ right |
| Ear Pain | ☐ left | ☐ right |
| Hearing Loss | ☐ left | ☐ right |
| Itchiness or Stuffiness in Ears | ☐ left | ☐ right |
| Pain Behind the Ear | ☐ left | ☐ right |
| Pain in Front of the Ear | ☐ left | ☐ right |
| Recurrent Ear Infections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



**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: _____

# GAD-7 Anxiety

| Over the last two weeks, how often have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid, as if something awful might happen | 0 | 1 | 2 | 3 |

Column totals _____ + _____ + _____ + _____ =

*Total score* _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

**Have you ever experienced:** ___Physical Abuse ___Verbal Abuse ___Emotional Abuse ___Sexual Abuse ___None
(Optional - check applicable)

If yes, please explain (optional):_____

# PHQ - 9

Over the last *2 weeks* have you been bothered by any of the following problems?
**(use "X" to indicate your answer)**

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

add columns _____ + _____ + _____

*(Healthcare professional: For interpretation of TOTAL please refer to the accompanying scoring card).*

TOTAL _____

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very Difficult _____
- Extremely difficult _____

Patient Initials: _____

## Additional Information

Is there anything else you would like us to know?

## Signature

I agree, the above information is accurate and complete to the best of my knowledge.

Patient Signature: _____Date: _____

Parent/Guardian Signature: _____Date: _____