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

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

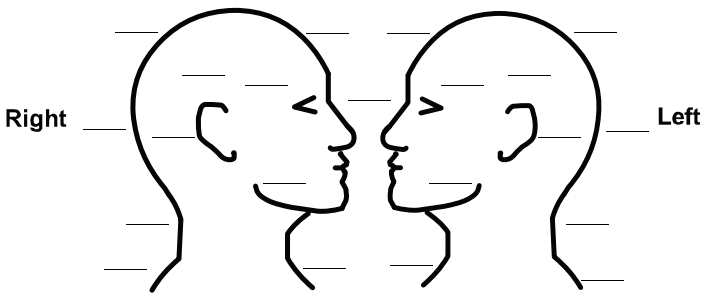
Are you currently experiencing any ear related conditions? ☐ yes ☐ no

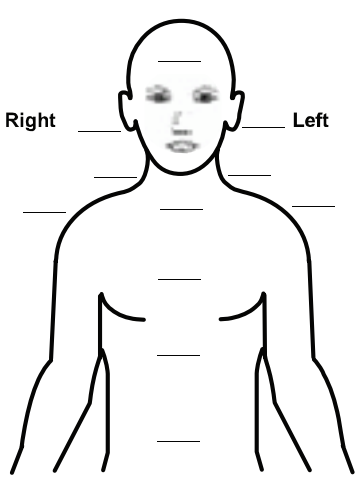
If yes, please indicate all that apply:

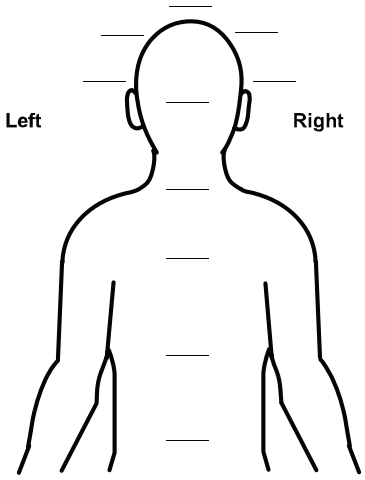
Ear Congestion	☐ left	☐ right
Ear Pain	☐ left	☐ right
Hearing Loss	☐ left	☐ right
Itchiness or Stuffiness in Ears	☐ left	☐ right
Pain Behind the Ear	☐ left	☐ right
Pain in Front of the Ear	☐ left	☐ right
Recurrent Ear Infections	☐ left	☐ right
Ringing in the Ear	☐ left	☐ right

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: (Optional - check applicable)

☐ Physical Abuse ☐ Verbal Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ None

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: _____