TMJ & SLEEP THERAPY CENTRE OF MONTANA
Schuyler A. VanDyke, DMD
401 15th Ave S, Suite 102
Great Falls, MT 59405

Initial Consultation

Name: _____ Date: _____

What have you tried doing to resolve this problem that <u>Did Not</u> work?

_____

_____

Have you become discouraged or stressed about handling this problem?

_____

_____

When your problem is at its worst, how does it make you feel? _____

How does this problem interfere with the following areas in your life?

Work: _____
Family: _____
Hobbies: _____
Life: _____

When it's at its worst, how much older does this make you feel? _____

Do you know how this problem may have started? _____

_____

What effect does this have on your body functions? _____

_____

How have you taken care of your health in the past?

Medications
Routine medical
Exercise
Diet and Nutrition
Holistic
Vitamins
Chiropractic
Other: _____

How did the previous methods work for you? _____

_____

What are you afraid this might be or will be affecting without change? Please circle

Job
Kids
Marriage
Sleep
Freedom
Future abilities
Finances
Time

Are there any health conditions you are afraid this might turn into?

Diminished Future abilities
Stress
Weight gain
Heart disease
Depression
Surgery
Arthritis
Cancer
Diabetes
Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific

_____

_____

_____

What would be different or better without this problem? Please circle:

Diminished stress
More energy
Self esteem
Confidence
Sleep
Work
Outlook
Family

If we were to sit down and discuss your life <u>3 years</u> from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

_____

_____

_____

_____

_____

_____

What potential barriers do you foresee that would prevent these things from happening?

_____

_____

_____

Do you feel it is possible to eliminate or prevent these potential barriers?

_____

_____

_____

What are your strengths that will enable you to accomplish your goals?

_____

_____

_____

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?
_____ Do you feel that you are coachable and would enjoy a mentor in helping you?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Thank You!

Comprehensive Health Questionnaire

Demographic Information

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

First Name:_____Middle Initial:_____ Last Name:_____

Age: _____ Date of Birth:_____ Height: _____ Weight: _____

Ethnicity: ☐Native American/Alaska Native ☐Asian ☐African American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other ☐Decline to Answer

Responsible Party/Legal Guardian (if different than patient): _____ Relationship: _____

Contact Information

Address:_____ Address 2: _____

City: _____ State: _____ Zip: _____

Email: _____ Home/Cell: _____

Employer: _____ Work Phone: _____

Referred by: _____ ☐ Dentist ☐ Physician ☐ Patient ☐ Other

Provider Information

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ Office Phone: _____

City: _____ Sate: _____ Zip: _____

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ Sate: _____ Zip: _____

Additional Provider Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ Sate: _____ Zip: _____

Patient/Parent Signature: _____ **Date:** _____

Please answer below for: What is your chief concern and reason for this visit?

_____

_____

Do you currently experience any of the following symptoms?

Please number your top chief complaints 1-4

Recent is in the last 6 months, Chronic is longer than 6 months

	Recent	Chronic
____ Back Pain	☐	☐
____ Chewing Pain	☐	☐
____ Ear Pain	☐	☐
____ Eye Pain	☐	☐
____ Facial Pain	☐	☐
____ Headache (inside head)	☐	☐
____ Headache (outside head)	☐	☐
____ Jaw Pain	☐	☐
____ Neck Pain	☐	☐
____ Nerve Pain	☐	☐
____ Shoulder Pain	☐	☐
____ Tooth Pain	☐	☐
____ Throat Pain	☐	☐
____ Difficulty Closing Mouth	☐	☐
____ Difficulty Opening Mouth	☐	☐
____ Dizziness	☐	☐
____ Dyskinesia	☐	☐
____ Ear Stuffiness (congestion)	☐	☐
____ Ear Itching	☐	☐
____ Jaw Locking Open	☐	☐
____ Jaw Locking Closed	☐	☐
____ Muscle Spasm	☐	☐
____ Noises in Jaw Joints	☐	☐
____ Numbness (Localized)	☐	☐
____ Ringing in Ears (Tinnitus)	☐	☐
____ Sinus Congestion	☐	☐
____ Vision Problems	☐	☐
____ Changes in Bite	☐	☐
____ Dental Pain	☐	☐
____ Teeth Crowding or Spacing issues	☐	☐

	Recent	Chronic
____ Teeth Sensitivity	☐	☐
____ Acid Indigestion	☐	☐
____ Affect Sleep of Others	☐	☐
____ Difficulty Falling Asleep	☐	☐
____ Dry Mouth Upon Waking	☐	☐
____ Fatigue	☐	☐
____ Feeling Un-refreshed in the AM	☐	☐
____ Frequent Heavy Snoring	☐	☐
____ Morning Headaches	☐	☐
____ Morning Hoarseness	☐	☐
____ Night Sweats	☐	☐
____ Nighttime Awakenings	☐	☐
____ Nighttime Choking	☐	☐
____ Nighttime Urination	☐	☐
____ Shortness of Breath	☐	☐
____ Significant Daytime Drowsiness	☐	☐
____ Sore Jaw Upon Waking	☐	☐
____ Swelling in Ankles or Feet	☐	☐
____ Told I Stop Breathing at Sleep	☐	☐
____ Teeth Grinding	☐	☐
____ Teeth Clenching	☐	☐
____ Tossing and Turning Frequently	☐	☐
____ Unable to Tolerate C-Pap	☐	☐
____ Vivid Dreams	☐	☐
____ Jaw/Facial Fatigue upon waking	☐	☐
____ Kicking or jerking of leg(s)	☐	☐
____ Any other symptoms not listed: _____		

_____

What is your level of head, neck or facial pain: 0 = no pain to 10 = worst possible pain

Currently: _____ At its best: _____ At its worst: _____

What are the results you are seeking from treatment?

_____

_____

Patient/Parent Signature: _____ Date: _____

Sleep Conditions - Please select the yes or no answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Position? ☐Side ☐Back ☐Stomach ☐Varies
Sleep Location? ☐Bed ☐Couch ☐Chair ☐Other
Bed Partner? ☐Yes ☐No
Average hours you sleep during the night? _____
Is it easy to fall asleep? ☐**Yes** ☐**No**
How many hours do you sleep during the day?_____
Do you wake often during the night? ☐**Yes** ☐**No**
Cough, gasps or snorts on waking? ☐Yes ☐No
Do you feel rested upon waking? ☐Yes ☐No
Observed pauses in breath? ☐Yes ☐No
Stopped breathing during sleep? ☐Yes ☐No
Have you ever had a Sleep Study? ☐Yes ☐No ☐HST ☐PSG Date: _____ Result: _____
Previous Positive Airway Pressure Devices Used? ☐CPAP ☐BiPAP ☐ASV ☐APAP
Do you currently use a PAP Device? ☐Yes ☐No Type: _____
Have you previously used a Nighttime Oral Appliance? ☐Yes ☐No Type: _____

Allergic Reactions

Please check any and all medications or substance that have caused an allergic reaction

☐ Anesthetics ☐ Antibiotics ☐ Aspirin
☐ Barbiturates ☐ Codeine ☐ Iodine
☐ Latex ☐ Metals ☐ Plastics
☐ Penicillin ☐ Sedatives ☐ Sulfa
☐ Food Allergies/Sensitivities _____
Other: _____

Current Medications

Please list all medications & supplements *(over-the-counter & prescription) you are taking and the reason you take them* ***OR Provide a copy of your personal Medication List***

Medication	Dose	Reason for Taking

☐ **See attached list**

Previous Treatment, Medications and Other Therapies Attempted For The Condition We Are Evaluating

Treatment/Medication	Doctor/Provider	Approximate Date of Treatment

☐ See attached

Health And Medical History

FOR FEMALE PATIENTS: 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 or take sedatives for pain relief or sleeping aid? ☐Yes ☐No
Do you have trouble breathing through your nose? ☐Yes ☐No
Have you had prior orthodontic treatments? ☐Yes ☐No
Have you sustained injury to: ☐Head ☐Neck ☐Face ☐Teeth
☐Other: _____ Approximate Date:_____

Surgical History - *Have you had any of the following:*

General Anesthesia ☐Yes ☐No
Adenoids Removed ☐Yes ☐No
Tonsils Removed ☐Yes ☐No
Jaw Joint Surgery ☐Yes ☐No
Orthognathic Surgery ☐Yes ☐No
Oral Surgery ☐Yes ☐No
Removal of Third Molar(s) (Wisdom Teeth) ☐Yes ☐No
Other types of surgery:_____

Patient/Parent Signature: _____ **Date:** _____

Medical History – Patient and Family

Do you have or have experienced any of the following?

	PATIENT HX	FAMILY HX
AIDS/HIV	☐ Yes ☐ No	
Anemia	☐ Yes ☐ No	☐ Fam Hx
Anxiety	☐ Yes ☐ No	☐ Fam Hx
Asthma	☐ Yes ☐ No	☐ Fam Hx
Awakenings from Sleep x	☐ Yes ☐ No	☐ Fam Hx
Bleeding Easily	☐ Yes ☐ No	☐ Fam Hx
Birth Defects	☐ Yes ☐ No	☐ Fam Hx
Bruising Easily	☐ Yes ☐ No	☐ Fam Hx
Cancer of _____	☐ Yes ☐ No	☐ Fam Hx
Chemo	☐ Yes ☐ No	☐ Fam Hx
Chronic Fatigue	☐ Yes ☐ No	☐ Fam Hx
Cold Hands and Feet	☐ Yes ☐ No	☐ Fam Hx
COPD	☐ Yes ☐ No	☐ Fam Hx
Depression	☐ Yes ☐ No	☐ Fam Hx
Diabetes	☐ Yes ☐ No	☐ Fam Hx
Difficulty Concentrating	☐ Yes ☐ No	☐ Fam Hx
Difficulty Breathing at Night	☐ Yes ☐ No	☐ Fam Hx
Dizziness	☐ Yes ☐ No	☐ Fam Hx
Eating Disorder	☐ Yes ☐ No	☐ Fam Hx
(EDS) Ehlers-Danlos Syndrome	☐ Yes ☐ No	☐ Fam Hx
Emphysema	☐ Yes ☐ No	☐ Fam Hx
Epilepsy	☐ Yes ☐ No	☐ Fam Hx
Excessive Thirst	☐ Yes ☐ No	☐ Fam Hx
Fainting	☐ Yes ☐ No	☐ Fam Hx
Fibromyalgia	☐ Yes ☐ No	☐ Fam Hx
Fluid Retention	☐ Yes ☐ No	☐ Fam Hx
Frequent Colds/Flu	☐ Yes ☐ No	☐ Fam Hx
Frequent Cough	☐ Yes ☐ No	☐ Fam Hx
Frequent Ear Infections	☐ Yes ☐ No	☐ Fam Hx
Frequent Sore Throat	☐ Yes ☐ No	☐ Fam Hx
Gastroesophogeal Reflux	☐ Yes ☐ No	☐ Fam Hx
Glaucoma	☐ Yes ☐ No	☐ Fam Hx
Hay Fever	☐ Yes ☐ No	☐ Fam Hx
Hearing Impairment	☐ Yes ☐ No	☐ Fam Hx
Heart Attack	☐ Yes ☐ No	☐ Fam Hx
Heart Disease	☐ Yes ☐ No	☐ Fam Hx
Heart Murmur	☐ Yes ☐ No	☐ Fam Hx
Heart Pacemaker	☐ Yes ☐ No	☐ Fam Hx
Heart Palpitations	☐ Yes ☐ No	☐ Fam Hx
Heart Valve Replacement	☐ Yes ☐ No	☐ Fam Hx
Hemophilia	☐ Yes ☐ No	☐ Fam Hx
Hepatitis	☐ Yes ☐ No	☐ Fam Hx
High Blood Pressure	☐ Yes ☐ No	☐ Fam Hx
History of Substance Abuse	☐ Yes ☐ No	☐ Fam Hx
Huntington's Disease	☐ Yes ☐ No	☐ Fam Hx

☐ **I HAVE NO FAMILY HX**

	PATIENT HX	FAMILY HX
Hypoglycemia	☐ Yes ☐ No	☐ Fam Hx
Insomnia	☐ Yes ☐ No	☐ Fam Hx
Intestinal Disorder	☐ Yes ☐ No	☐ Fam Hx
Irregular Heartbeat	☐ Yes ☐ No	☐ Fam Hx
Kidney Disease	☐ Yes ☐ No	☐ Fam Hx
Leukemia	☐ Yes ☐ No	☐ Fam Hx
Liver Disease	☐ Yes ☐ No	☐ Fam Hx
Low Blood Pressure	☐ Yes ☐ No	☐ Fam Hx
Meniere's Disease	☐ Yes ☐ No	☐ Fam Hx
Memory Loss	☐ Yes ☐ No	☐ Fam Hx
Migraines	☐ Yes ☐ No	☐ Fam Hx
Mitral Valve Prolapse	☐ Yes ☐ No	☐ Fam Hx
Multiple Sclerosis	☐ Yes ☐ No	☐ Fam Hx
Muscle Aches	☐ Yes ☐ No	☐ Fam Hx
Muscle Fatigue	☐ Yes ☐ No	☐ Fam Hx
Muscle Spasms	☐ Yes ☐ No	☐ Fam Hx
Muscular Dystrophy	☐ Yes ☐ No	☐ Fam Hx
Neuralgia	☐ Yes ☐ No	☐ Fam Hx
Nervous system Disorder	☐ Yes ☐ No	☐ Fam Hx
Osteoarthritis	☐ Yes ☐ No	☐ Fam Hx
Osteoporosis	☐ Yes ☐ No	☐ Fam Hx
Ovarian Cyst	☐ Yes ☐ No	☐ Fam Hx
Parkinson's Disease	☐ Yes ☐ No	☐ Fam Hx
Poor Circulation	☐ Yes ☐ No	☐ Fam Hx
(POTS) Postural Orthostatic Tachycardia Syndrome	☐ Yes ☐ No	☐ Fam Hx
Psychiatric Care	☐ Yes ☐ No	☐ Fam Hx
Radiation	☐ Yes ☐ No	☐ Fam Hx
Recent Weight Gain	☐ Yes ☐ No	☐ Fam Hx
Recent Weight Loss	☐ Yes ☐ No	☐ Fam Hx
Rheumatic Fever	☐ Yes ☐ No	☐ Fam Hx
Rheumatoid Arthritis	☐ Yes ☐ No	☐ Fam Hx
Scarlet Fever	☐ Yes ☐ No	☐ Fam Hx
Shortness of Breath	☐ Yes ☐ No	☐ Fam Hx
Skin Disorder	☐ Yes ☐ No	☐ Fam Hx
Sinus Problems	☐ Yes ☐ No	☐ Fam Hx
Slow Healing Sores	☐ Yes ☐ No	☐ Fam Hx
Speech Difficulties	☐ Yes ☐ No	☐ Fam Hx
Stroke	☐ Yes ☐ No	☐ Fam Hx
Swollen or Painful Joints	☐ Yes ☐ No	☐ Fam Hx
Thyroid Disease	☐ Yes ☐ No	☐ Fam Hx
Tired Muscles	☐ Yes ☐ No	☐ Fam Hx
Tuberculosis	☐ Yes ☐ No	☐ Fam Hx
Urinary Tract Disorder	☐ Yes ☐ No	☐ Fam Hx

OTHER _____

Patient/Parent Signature: _____ **Date:**_____

Additional Symptoms – HEAD PAIN **Please complete for all that apply:**

1. **Do you experience General Head Pain?** ☐Yes ☐No

	Location (L = Left R = Right B = Bilateral)	Recent/Chronic (over 6mo)	Severity	Duration	Frequency
2. Temple Area	☐L ☐R ☐B	☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
3. Back of Head	☐L ☐R ☐B	☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
4. Forehead	☐L ☐R ☐B	☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
5. Top of Head	☐L ☐R ☐B	☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐

Severity	Mild	Mod	Severe
	☐	☐	☐

Duration	Hrs	Days	Wks
	☐	☐	☐

Frequency	Occ.	Freq	Constant
	☐	☐	☐

For the below categories, please indicate L or R where applicable

Jaw Pain ☐ I have no jaw pain

Jaw pain with opening	☐L	☐R
Jaw pain when chewing	☐L	☐R
Jaw pain at rest	☐L	☐R

Jaw Joint Sounds ☐ I have no jaw joint sounds

Jaw sounds with opening	☐L	☐R
Jaw sounds when chewing	☐L	☐R

Ear Related Conditions

Buzzing in ears	☐L	☐R	Pain behind the ear	☐L	☐R
Ear Congestion	☐L	☐R	Pain in front of ear	☐L	☐R
Ear pain	☐L	☐R	Recurrent ear infections	☐L	☐R
Hearing Loss	☐L	☐R	Ringing in the ear (tinnitus)	☐L	☐R
Itchiness/stuffiness	☐L	☐R			

For the below categories, please respond with Yes or No .... *DO NOT LEAVE BLANK*

Jaw Locking

Jaw locks closed	☐Yes	☐No
Jaw locks open	☐Yes	☐No

Jaw Joint Symptoms

Teeth clenching	☐Yes	☐No	☐Day	☐Night
Teeth grinding	☐Yes	☐No	☐Day	☐Night

Eye Related Conditions

Blurred vision	☐Yes	☐No	Pain or pressure behind the eyes	☐Yes	☐No
Double vision	☐Yes	☐No	Extreme sensitivity to light	☐Yes	☐No
Eye pain	☐Yes	☐No	Wear of glasses or contacts	☐Yes	☐No

Throat Related Conditions

Chronic sore throat	☐Yes	☐No	Thyroid enlargement	☐Yes	☐No
Difficulty Swallowing	☐Yes	☐No	Tightness in throat	☐Yes	☐No
Swollen glands	☐Yes	☐No	Feeling of foreign object in throat	☐Yes	☐No

Neck related Conditions

Limited movement	☐Yes	☐No	Numbness in hands/fingers	☐Yes	☐No
Neck pain	☐Yes	☐No	Swelling in neck	☐Yes	☐No

Shoulder Conditions

Pain in Shoulders	☐Yes	☐No	Tingling in fingers/hands	☐Yes	☐No
Stiffness in Shoulders	☐Yes	☐No			

Back Conditions

Low Back Pain	☐Yes	☐No	Scoliosis	☐Yes	☐No
Middle Back Pain	☐Yes	☐No	Sciatica	☐Yes	☐No
Upper Back Pain	☐Yes	☐No			

Mouth/Nose Conditions

Chronic Sinusitis	☐Yes	☐No	Broken Teeth	☐Yes	☐No
Dry Mouth	☐Yes	☐No	Biting Cheeks	☐Yes	☐No
Frequent Snoring	☐Yes	☐No	Burning Tongue	☐Yes	☐No

Patient/Parent Signature: _____ **Date:** _____

History of Symptoms

On what date, or approximate date, did the condition you are seeking treatment for occur? _____

Are any of the conditions listed or was your chief complaint caused by a motor vehicle accident? ☐Yes ☐No

If yes, what conditions: _____ Date of accident: _____

Does any family member have a sleep breathing disorder? ☐Yes ☐No If yes, explain: _____

_____

Please fully complete both sections 1. and 2. below

1. DAYTIME SLEEPINESS EVLAUATION - EPWORTH SLEEPINESS SCALE

For the following situations, answer with one of the following numbers:

0 - would never doze 1 - slight chance of dozing 2 - moderate chance of dozing 3 - high chance of dozing

Situation	Score	Situation	Score
Sitting and reading	_____	Sitting and talking to someone	_____
Watching Television	_____	Sitting quietly after a lunch (no alcohol)	_____
Sitting, inactive public place	_____	In a car, while stopped for a few minutes in traffic	_____
As a passenger in a car for an hour without a break	_____	Lying down to rest in the afternoon when circumstances permit	_____
		TOTAL SCORE	_____

2. NIGHTTIME SLEEPINESS EVALUATION

Developed by David White, M.D., Harvard Medical School, Boston, MA

1. Snoring — Score

   a) Do you snore on most nights (>3 nights per week)?
   Yes (2) No (0) _____

   b) Is your snoring loud? Can it be heard through a door or wall?
   Yes (2) No (0) _____

2. Has it ever been reported to you that you stop breathing or gasp during sleep?
   Never (0) Occasionally (3) Frequently (5) _____

3. What is your collar size?
   Male: Less than 17 inches (0) More than 17 inches (5)
   Female: Less than 16 inches (0) More than 16 inches (5) _____

4. Do you occasionally fall asleep during the day when:
   a) You are busy or active
   Yes (2) No (0) _____

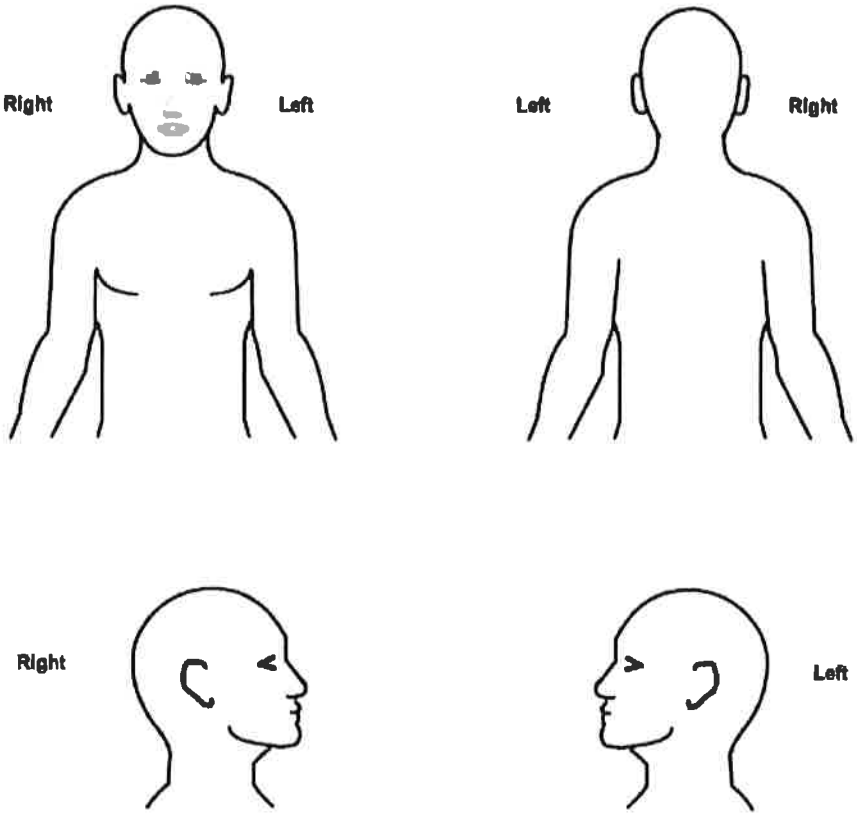
   b) You are driving or stopped at a light?
   Yes (2) No (0) _____

5. Have you had or are you being treated for high blood pressure?
   Yes (2) No (0) _____

TOTAL _____

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, third party billing companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance covers.

Patient/Parent Signature: _____ **Date:** _____



Indicate Areas of Pain
Following the Pain Scale:
1 Mild pain
2 Moderate pain
3 Severe pain

AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW LISTED REFERRING AND TREATING HEALTH CARE PROFESSIONALS:

Doctors Name _____ **Phone** _____

Primary: _____

Dentist: _____

_____

Chriropractor: _____

_____

Other: _____

I authorize the release of communications regarding my treatment with _____ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

Signed _____ Date _____

Patients printed Name: _____

Private Patient Agreement

I am aware TMJ & Sleep Therapy Centre is not contracted with my insurance company. I am requesting to be seen as a private patient and completely understand I will be responsible for full fees on a private pay basis. I agree to pay for treatment services at the TMJ & Sleep Therapy Centre at the fees schedule based on the centre's private practice charges.

_____

Signature Date

HIPAA – Privacy practices:

Acknowledgement of receipt of Notice of Privacy Practices:
I have received a copy of this office's Notice of Privacy Practices

_____

Signature Date

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize TMJ & Sleep Therapy Centre of Montana, Inc. and it's provider to view my external prescription history via Meditouch Practice Management. I understand that this includes but is not limited to prescription history from other unaffiliated medical providers, insurance companies, and/or pharmacy benefit managers may be viewable by provider and staff at TMJ & Sleep Therapy Centre of Montana, Inc. This also may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

_____

Signature Date