



**HAVE YOU EXPERIENCED THE FOLLOWING SYMPTOMS:**

Headaches: Migraines \_\_\_\_\_ Tension \_\_\_\_\_ Other \_\_\_\_\_

How often: \_\_\_\_\_

Location:	Top of Head	___ L ___ R ___	Temples	___ L ___ R ___
	Forehead	___ L ___ R ___	Behind the eyes	___ L ___ R ___
	Back of Head (Occipital)	___ L ___ R ___	Pain in Neck	___ L ___ R ___
	Pain in Shoulders	___ L ___ R ___	Pain in Ear	___ L ___ R ___
	Ear Congestion	___ L ___ R ___	Dizziness (Vertigo)	___ L ___ R ___
	Tinnitus (Ringing sound in Ears)	___ L ___ R ___	Facial Pain (non specific)	___ L ___ R ___
	Pain in Jaw Joint	___ L ___ R ___	Grating Sound in Joints	___ L ___ R ___
	Clicking or Popping Sound in Joints	___ L ___ R ___	<b>Constant</b> _____ <b>Sporadic</b> _____	
	Partial inability to open Mouth	___ L ___ R ___		

Face muscle twitch \_\_\_\_\_ Yes No \_\_\_\_\_  
 Difficulty swallowing \_\_\_\_\_ Yes No \_\_\_\_\_  
 Difficulty breathing through nose \_\_\_\_\_ Yes No \_\_\_\_\_  
 Difficulty chewing \_\_\_\_\_ Yes No \_\_\_\_\_

**Occlusal Habits**

**Do you:**

___ Clench or grind your teeth?	___ Cheek biting
___ Teeth hit in front first	___ Pipe smoking
___ Nail biting	___ Gum Chewing
___ Have previous dentists had difficulty in getting you numb?	
___ Have tired jaws, especially in the morning?	
___ Pencil Biting	Other _____

**POSTURAL HABITS**

___ Phone Cradling	___ Leans chin on hand	___ TV Watching	___ Heavy Lifting
___ Shoulder Bag	___ Musical Instruments	___ Athletic Activity –Strenuous, Moderate, None	
___ Heavy Lifting	___ Job (i.e. writing)	___ Sleep –stomach, side, back, hand under chin	
___ Other: _____			

**Have you had any of the following radiographs in the past three years?**

\_\_\_\_\_ Jaw Joints \_\_\_\_\_ MRI \_\_\_\_\_ CT Scans