TMJ/TMD

Name:_____ **Date:**_____

Age:_____ Sex: M F Height: _____ Weight: ____ Dominant hand: R L

SCHOOL INFORMATION: Grade:_____ School:_____

WORK INFORMATION: Do you have a job: Y N If yes, job: _____

SPORT INFORMATION: Current sport(s) and/or activities: _____

Position(s) played/event(s):_____ How long have you been playing:_____

Team name(s):_____

HISTORY OF INJURY: How did your problem occur?:_____

_____

Date of Onset:_____ Involved Side: R L Both Next Physician Follow-up:_____

Describe any previous problems with this area: _____

MEDICAL INFORMATION: Family Physician:_____

Referring Physician:_____ Diagnosis: _____

Medical Tests: X-Ray___ CT Scan___ Bone Scan___ MRI___ EMG___ NCV___ ImPACT___
Arthrogram___ Ultrasound___ Other:_____ Results:_____

Did you have surgery? Y N Date:_____/_____/_____

Did you use: Cast ____Splint___ Brace___ Boot___ Date Used:___/___/____ - ___/___/___

Do you drink or smoke: Y N **Females:** Have you started menstruating? Y N Age of first period: ___

Have you ever been diagnosed with any of the following conditions?

__Y	__N	Cancer (Type:_____)	__Y	__N	Juvenile Rheumatoid Arthritis
__Y	__N	Heart or Circulation Problems	__Y	__N	Other Arthritic Conditions
__Y	__N	High Blood Pressure	__Y	__N	Mononucleosis
__Y	__N	Depression/Anxiety/OCD (Circle)	__Y	__N	Ehler's Danlos/Hypermobility
__Y	__N	Asthma (Worse with:_____)	__Y	__N	Latex Allergy
__Y	__N	Allergies	__Y	__N	Anemia
__Y	__N	Disordered Eating	__Y	__N	Osteoporosis/Osteopenia/Stress fractures
__Y	__N	Urinary Leakage/Pelvic Floor Issues	__Y	__N	Lyme disease
__Y	__N	Thyroid Problems	__Y	__N	Learning disability/ADHD
__Y	__N	Diabetes (Type I/II)	__Y	__N	Concussion (#:_____)

Please turn over and complete the other side

List any medications (including prescriptions, over-the-counter, herbals, vitamin/mineral/dietary supplements) you are currently taking:

	Name of Med./Supplement	Dosage	Frequency of Use	Route of Administration
1.				
2.				
3.				
4.				
5.				

FUNCTION:

Indicate any activities that you have difficulty completing (chewing, eating, talking, working, smiling, laughing, school work, sports, throwing, reaching, lifting, sleeping)

_____

What are your goals for Physical Therapy? _____

PAIN: (select your pain level from the following number scale)

Circle the amount of your pain at best- (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Circle the amount of your pain at worst- (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Amount of pain with rest _____ (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Amount of pain with activity _____ (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Is your pain: Constant____ Intermittent____
Since the onset of pain, is your pain: Improving____ Worsening_____ Unchanged____

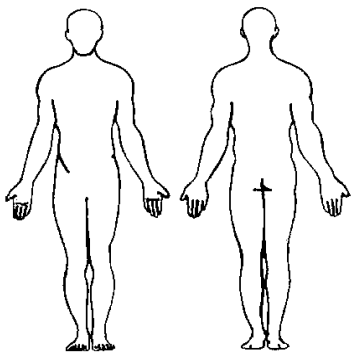
Do you have: Ringing in the ears Clicking Locking Grinding Headaches Popping

Activities that increase pain (please circle): chewing, eating hard foods, eating soft foods, sleeping, talking, smiling, laughing, exercising, drinking, social activities, recreational activities, self-care, stress, work, other: _____

Activities that increase pain:_____
Activities that decrease pain:_____

Please mark on the drawing and/or lists below the areas where you feel your pain:

Head/neck: Y N
Upper/mid back: Y N
Low back: Y N
Shoulders: Y N
Elbows: Y N
Wrists/hands: Y N
Hips: Y N
Knees: Y N
Ankles/feet: Y N
Other: Y N



Other Concerns/Questions:_____
_____
_____
_____
_____
_____
_____
_____
_____

Please tell us how you heard about us!

Please circle your response below (please circle all that apply):

Family physician/pediatrician

Specialist/orthopedist

Other medical provider (neurologist, rheumatologist, dentist, orthodontist, chiropractor, etc)

Athletic trainer

Coach

Massage therapist

Friend or family member

Flyer or other marketing material

Prior patient

Injury prevention program with your sports team

Other: _____

Please tell us the name of your referral source so we can thank them: _____