TruDenta®

HEAD HEALTH HISTORY

PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

#	DENTAL FOUNDATION (TEETH, MUSCLES, JOINTS)		
1	Have you noticed a change in the way your teeth fit together? » If 'Yes', it is because of ☐ Dental Changes ☐ Trauma ☐ Other	☐ Yes	☐ No
2	Where do you think your teeth hit or fit first? ☐ More on the right ☐ Left ☐ Equal ☐ More on the front ☐ Back ☐ Equal		
3	Do your jaw muscles get tight or sore? » When? ☐ Morning ☐ Evening ☐ After chewing	☐ Yes	☐ No
4	Do you have pain or difficulty opening wide?	☐ Yes	☐ No
5	Are you aware of noises in your jaw joints? ☐ Popping ☐ Clicking ☐ Other » Where? ☐ Right ☐ Left ☐ Both » How long? ☐ Less than 1 year ☐ More than 1 year	☐ Yes	☐ No
	CAUSES & COMPLICATIONS		
6	Do you grind or clench your teeth? » Do you wear a? ☐ Splint ☐ Night Guard ☐ Retainer	☐ Yes	☐ No
7	Have you had any significant dental treatments? ☐ Orthodontics ☐ Oral surgery / wisdom teeth removal ☐ Long dental appointments ☐ Other	☐ Yes	☐ No
8	Have you been in a car accident, major or minor? » How many? _____ » When was the last accident? ☐ 0-6 Months ☐ 6-12 Months ☐ More than 1 year » Did you see the accident coming? ☐ Yes ☐ No » Did the airbag deploy? ☐ Yes ☐ No	☐ Yes	☐ No
9	Have you had sports injuries and/or trauma to your head & neck? » When? ☐ Less than 1 year ☐ More than 1 year	☐ Yes	☐ No
10	Do you work at a desk, computer or in a forward head posture position? » Do you have any other postural position problems? _____	☐ Yes	☐ No
11	Daytime sleepiness, drowsiness, or tiredness?	☐ Yes	☐ No
12	Problems with sleep? » Insomnia ☐ Yes ☐ No » Sleep Apnea ☐ Yes ☐ No » Sleep Disturbances ☐ Yes ☐ No » Less than 7 hours per night ☐ Yes ☐ No » Other _____		

#	SYMPTOMS
13	Do you experience pain in » Jaw ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Face ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Neck ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Shoulders ☐ Right ☐ Left ☐ Both ☐ More than 1 year » Arms ☐ Right ☐ Left ☐ Both ☐ More than 1 year
14	Do you experience ringing or fullness in your ears? ☐ Yes ☐ No » Which one? ☐ Right ☐ Left ☐ Both
15	How often do you get severe headaches/migraines that makes it difficult to function without treatment or medication? ☐ Occasionally ☐ More than twice a year ☐ More than once a month ☐ More than once a week ☐ Never
16	How often do you get other milder headaches? ☐ Daily ☐ More than 3 per week ☐ More than 2 per month ☐ Other _____
17	Have your headaches changed in the last six months? ☐ About the same ☐ Slight worsening ☐ Same but more frequent ☐ A lot worse Got worse when _____
#	**IMPACT ON DAILY LIVING ACTIVITIES**
18	What is your stress level? ☐ Mild ☐ Moderate ☐ Severe
19	Do you have anxiety? ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe
20	Because of pain, headaches or migraines, in the last month: # Of days you could not go to school _____ # Of days you did reduced amount of work _____ # Of days you could not do usual household work/parenting _____ # Of days you missed family or social functions _____
21	When you have pain, headaches or migraines, how does that make you feel? *(Check all that apply)* ☐ Angry ☐ Depressed ☐ Tired or exhausted ☐ Frustrated ☐ Guilty ☐ Ashamed ☐ Relationship tension ☐ Other _____
	NOTES: _____

FOR OFFICE USE ONLY

Pain/Headache/Migraine Impact Score:

MILD - 1 MODERATE -2 SEVERE - 3

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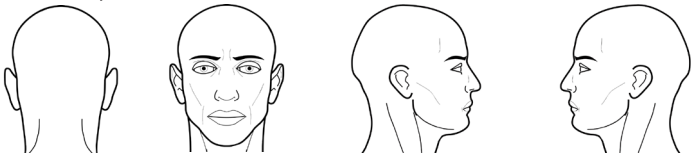
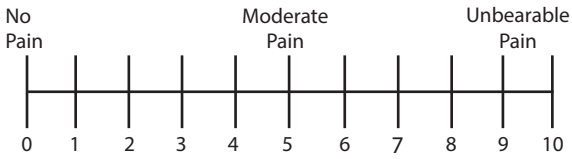
Please review and answer all parts of each question with our staff. Provide specific details/notes in the right hand column.

#	QUESTIONS
1	How often do you get severe headaches/migraines that make it difficult to function without treatment or medication? » ☐ Occasionally » ☐ More than twice a year » ☐ More than once a month » ☐ More than once a week
2	How often do you get other milder headaches? » ☐ Daily » ☐ More than 3 per week » ☐ More than 2 per month » ☐ Other Please specify: _____
3	Have your headaches changed in the last six months? » ☐ About the same » ☐ Slight worsening » ☐ Same but more frequent » ☐ A lot worse » ☐ New type of headache » ☐ Got worse when _____
4	Where are your headaches located? (Mark Locations)  Back Front Right Side Left Side On a scale of 1-10, how painful are your headaches/migraines? 
5	Describe the type of headache pain you feel most often: » ☐ Achy » ☐ Throbbing » ☐ Stabbing » ☐ Other _____
6	What other doctors have you seen or tests have you had for your pain headaches, and/or migraines

☐ GP / FAMILY DOCTOR		☐ PHYSICAL THERAPIST	
☐ DENTIST (IF OTHER)		☐ CHIROPRACTOR	
☐ ORAL/MAXILLOFACIAL SPECIALIST		☐ MRI/CT SCAN/BLOOD WORK	
☐ PSYCHIATRIST/PSYCHOLOGIST		☐ OTHER	

7 What medications do you use for headache, migraine, or pain relief?

MEDICATION (NAME OF MEDICATION OR SUBSTANCE)	WHAT DOSE?	HOW OFTEN?
Acetaminophen, Tylenol		
Ibuprofen, Advil, Motrin, Nuprin, etc..		
Naproxin, Aleve		
Rx pain medication ( )		
Rx pain medication ( )		
Rx muscle relaxant ( )		
Rx anxiety medication ( )		
Rx depression medication ( )		
Rx migraine medication ( )		
Medication for sleeping ( )		
Caffeine intake ( )		
Alcohol intake ( )		
THC, Medical Marijuana ( )		
Other: ( )		

8 Do you try non-medicating techniques for managing your headaches? ☐ Yes ☐ No

» ☐ Yoga » ☐ Breathing Exercises » ☐ Cold Packs » ☐ Massage » ☐ Meditation » ☐ Physical Therapy

» ☐ Other (please describe) _____

I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION BEST DESCRIBES THE TREATMENTS AND MEDICATIONS I HAVE USED TO HELP ALLEVIATE MY HEADACHES/MIGRAINES/PAIN.

PATIENT SIGNATURE: _____