TMJ & Sleep Therapy Centre

CORRECTIVE CARE PATIENT HEALTH QUESTIONNAIRE

Today's Date: _____

Demographic Information

Last Name: _____ Middle Initial: _____ First Name: _____

Age: _____ Date of Birth: _____ SSN: _____ Sex: ☐ Male ☐ Female

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

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

☐ I authorize communications and consent to release and/or obtain any of my information regarding my treatment with Daniel G. Klauer, DDS including a full report of examination findings, diagnosis, treatment plan and progress report between TMJ & Sleep Therapy Centre and the professional care team listed above.

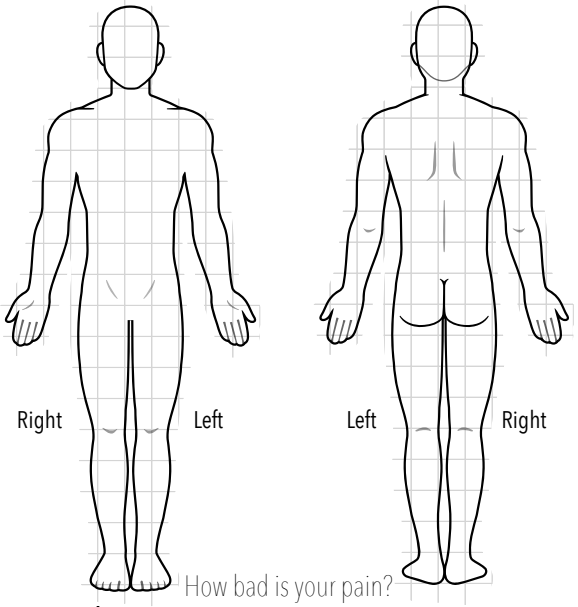
When was your last complete check up/physical? _____

When was your last pelvic/mammogram? _____

Current Pain Symptoms

Mark the areas on your body where you now feel pain. Include all affected areas. Use the appropriate codes indicated below.

ACHE >>>> **NUMBNESS** ---- **PINS & NEEDLES** oooo **BURNING** xxxx **STABBING** ////



How bad is your pain?

TMJ & Sleep Therapy Centre
7221 N. Fir Road
Granger, IN 46530

Reason for your visit if other than pain: _____

General Health History

Do you have any of the following conditions?

____Stomach/Intestinal Problems
____Diabetes
____Arthritis
____Gout
____Heart Problems
____Seizures
____Headaches
____Weakness in Arms/Legs
____Difficulty Controlling Bowel/Bladder Function
____Unexplained Weight Loss
____Loss of Appetite/Change in Taste of Food
____Thyroid Problems
____Hypertension
____Other _____

History of Onset

Why would you like to be seen? _____
Do you have pain? ☐ yes ☐ no where? _____
When did you first have this pain? _____
How did the current episode of pain occur?

____Gradual Onset
____Direct Blow
____Recreational Accident
____Non-work Related Incident
____Twisting
____Lifting
____On the Job Injury
____Pushing/Pulling
____Vehicle Accident
____No Known Cause
____Bending
____Fall
____Other: _____

If your pain is the result of an injury, please describe the incident and date of incident: _____

Is your pain the result of a motor vehicle accident? ☐ yes ☐ no Did you have pain prior to the accident? ☐ yes ☐ no
Have you previously been off work due to pain? ☐ yes ☐ no
If yes, about how many days of work have to missed due to pain in the last 2 years? _____

Accidents

Have you ever had any car accidents or bad falls (work injuries, sports injuries, etc) in which you were sore for at least 5 days? Please list how injury occurred,. when it occurred, why and where it occurred.

1. _____
2. _____
3. _____
4. _____

Current Symptoms

Circle a number below to indicate how much of a problem you are having with each of the following:

	NONE										SEVERE
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Poor Sleep	0	1	2	3	4	5	6	7	8	9	10

Mark the worst and best times of the day for your pain:

WORST ____First Awakening ____Morning ____Mid Day ____Afternoon ____Evening ____Nighttime

BEST ____First Awakening ____Morning ____Mid Day ____Afternoon ____Evening ____Nighttime

Patient Initials: _____

TMJ & Sleep Therapy Centre
7221 N. Fir Road
Granger, IN 46530

Current Symptoms, Continued

Circle a number below to indicate your level of pain:

	NONE										SEVERE
At its LEAST	0	1	2	3	4	5	6	7	8	9	10
At its WORST	0	1	2	3	4	5	6	7	8	9	10
TODAY	0	1	2	3	4	5	6	7	8	9	10

List specific activities that increase your pain:

1._____ 2._____ 3._____ 4._____

List specific methods or activities that relieve your pain:

1._____ 2._____ 3._____ 4._____

How often do you have to stop your activities and sit or lie down to control your pain?

____Occasionally ____Several times per day ____Approximately once per day ____Spend almost all day lying or sitting to control my pain

How much of the time during an average day are you in pain?

____<1 hour per day ____1-4 hours per day ____4-8 hours per day ____Almost anytime that I am not lying down ____Almost 24 hours per day

How would you describe your overall severity of pain?

____Mild Nuisance Pain ____Mild to Moderate - I can live with it ____Moderate - I am having difficulty dealing with it ____Severe - it is ruining my quality of life

____None - I have no pain

Function Index

Do you require help lifting? (i.e. 30-40 pounds, heavy suitcases, or a 3-4 year old child)	☐ yes	☐ no
Is your sitting generally limited to less than one-half hour?	☐ yes	☐ no
Is traveling in a car or bus generally limited to less than one-half hour?	☐ yes	☐ no
Is standing in one place generally limited to less than one-half hour?	☐ yes	☐ no
Is your walking generally limited to less than one-half hour?	☐ yes	☐ no
Do you regularly curtail or miss social activities because of your pain?	☐ yes	☐ no

Sleep Questionnaire

	Yes	No
Do you snore?		
Do you fall asleep at inappropriate times?		
Do you experience daytime sleepiness or fatigue?		
Do you have high blood pressure?		
Do you wake up gasping for breath?		
Do you have morning headaches?		
Do you have poor concentration, irritability, or memory loss?		
Do you have restless sleep or excessive leg movement at night?		
Have you experienced excessive weight gain?		
Do you have problems falling or staying asleep?		
Have you acted out a dream and hurt yourself or a bed partner?		
Do you get up frequently to urinate at night? About how many times?_____		
Do you wake up with a dry mouth?		
Have you had a sleep study?		
Do you use sleep medication?		
Do you use CPAP, AutoPAP, or an oral appliance?		

Patient Initials: _____

TMJ & Sleep Therapy Centre
7221 N. Fir Road
Granger, IN 46530

Prior Surgeries

	Procedure	Date
1.		
2.		
3.		
4.		
5.		

Pregnancies *(women only)*

How many? _____ Complications with Any? ☐ yes ☐ no If yes, what? _____

Did you have back pain with pregnancy? ☐ yes ☐ no Do you have pain with intercourse? ☐ yes ☐ no

Family Health History

Does your family have a history of any of the following?

Cancer	☐ Yes	☐ No	Who?
Obesity (overweight)	☐ Yes	☐ No	Who?
High Blood Pressure	☐ Yes	☐ No	Who?
Heart Trouble	☐ Yes	☐ No	Who?
Stroke	☐ Yes	☐ No	Who?
Asthma	☐ Yes	☐ No	Who?
Allergies	☐ Yes	☐ No	Who?
Diabetes (sugar)	☐ Yes	☐ No	Who?
Ulcers	☐ Yes	☐ No	Who?
Stomach or Bowel Problems	☐ Yes	☐ No	Who?
Gout	☐ Yes	☐ No	Who?
Kidney Disease	☐ Yes	☐ No	Who?
Arthritis	☐ Yes	☐ No	Who?
Hay Fever	☐ Yes	☐ No	Who?
Nerve/Muscle Diseases	☐ Yes	☐ No	Who?
Seizures (fits, epilepsy)	☐ Yes	☐ No	Who?
Anemia (low blood)	☐ Yes	☐ No	Who?
Bleeding Problems	☐ Yes	☐ No	Who?
Rheumatic Fever	☐ Yes	☐ No	Who?
Alcoholism	☐ Yes	☐ No	Who?
Mental Illness	☐ Yes	☐ No	Who?
Physical Deformity	☐ Yes	☐ No	Who?
Blind/Deaf	☐ Yes	☐ No	Who?
Mental Retardations	☐ Yes	☐ No	Who?
Hereditary Problem	☐ Yes	☐ No	Who?
Death by Accident	☐ Yes	☐ No	Who?

Other problems not mentioned: _____

TMJ & Sleep Therapy Centre
7221 N. Fir Road
Granger, IN 46530

Social History

Last grade of school completed: _____

Are you employed? ☐ yes ☐ no Occupation: _____

Special diet: _____

Have you been a victim of physical, sexual, verbal, or mental/emotional abuse? ☐ yes ☐ no
If yes, please explain (optional): _____

Did/do you smoke? ☐ yes ☐ no If yes, how many packs/day and for how long? _____
If you quit, how many packs/day were you smoking? _____ How long did you smoke before quitting? _____
How long has it been since you quit smoking? _____
Did/do you drink alcohol? ☐ yes ☐ no If yes, how much/day? _____
Do you drink alcohol to control pain? ☐ yes ☐ no
If you quit, how much/day were you drinking? _____ How long did you drink before quitting? _____
How long has it been since you quit drinking? _____
Do you drink coffee? ☐ yes ☐ no If yes, how many cups/day? _____

Do you have a home exercise program you do on a regular basis? ☐ yes ☐ no
Do you exercise daily? ☐ yes ☐ no

Medication History

Do you have allergies to medications? ☐ yes ☐ no
If yes, please list: _____

Do you have environmental or food allergies? ☐ yes ☐ no
If yes, please list: _____

List all the medications (prescription and non-prescription) you are currently taking. Put a star next to the ones you are taking for pain.

Medication	Dosage

Prior Treatment for your Problem

Type of Provider	Provider's Name	Location	Approximate Date(s)

Have you been satisfied with previous medical care? ☐ yes ☐ no
If no, comment (optional): _____

TMJ & Sleep Therapy Centre
7221 N. Fir Road
Granger, IN 46530

Mark each type of treatment you have had for your back/neck or pain problem in the past. Then check the column that best describes the effect of the treatment. If you have had treatments not given on the list, write them at the bottom and indicate how they effected you.

Treatment	Helped	Made things worse	Didn't do much either way	Time to improvement (months)
Stretching Exercises				1-3 3-6 6-12>
Hot Packs				1-3 3-6 6-12>
Ultrasound				1-3 3-6 6-12>
Ice				1-3 3-6 6-12>
Massage				1-3 3-6 6-12>
Electrical Stimulation during Physical Therapy				1-3 3-6 6-12>
TENS Unit for Home Use				1-3 3-6 6-12>
Body Mechanics Training				1-3 3-6 6-12>
Strengthening Exercises				1-3 3-6 6-12>
Aerobics (e.g. exercise bike)				1-3 3-6 6-12>
Gravity Inversion				1-3 3-6 6-12>
Traction				1-3 3-6 6-12>
Bed Rest				1-3 3-6 6-12>
Chiropractic Treatment				1-3 3-6 6-12>
Osteopathic Manipulation				1-3 3-6 6-12>
Biofeedback				1-3 3-6 6-12>
Local (Trigger Point) Injections				1-3 3-6 6-12>
Epidural Injections				1-3 3-6 6-12>
Facet Joint Injections				1-3 3-6 6-12>
Back Brace				1-3 3-6 6-12>
Prolotherapy/PRP				1-3 3-6 6-12>
Acupuncture				1-3 3-6 6-12>
Anti-inflammatory Medication				1-3 3-6 6-12>
Narcotic Pain Medication				1-3 3-6 6-12>
Muscle Relaxant Medication				1-3 3-6 6-12>
Anti-depressant Medication				1-3 3-6 6-12>
Surgery				1-3 3-6 6-12>
Other				1-3 3-6 6-12>

Which of the following diagnostic tests have been done on your back/neck? Please indicate date for "yes" answers. Please state if you have been unable to complete any of these tests, or have had a severe reaction to any of them:

Regular Spine (x-rays) ☐ yes ☐ no Approx. Date:_____
CT Scan ☐ yes ☐ no Approx. Date:_____
Myelogram ☐ yes ☐ no Approx. Date:_____
MRI Scan ☐ yes ☐ no Approx. Date:_____
Bone Scan ☐ yes ☐ no Approx. Date:_____
EMG ☐ yes ☐ no Approx. Date:_____
Other ☐ yes ☐ no Approx. Date:_____

Results *(Doctor's use only)*

Patient Initials: _____

TMJ & Sleep Therapy Centre
7221 N. Fir Road
Granger, IN 46530

To be sure paperwork is filled out correctly, please check if appropriate:

___**Motor Vehicle Accident** Claim #: _____ Date of Accident _____

Auto Insurance Company Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

___**Workman's Compensation Case** Employer: _____

Caseworker Name: _____ Case #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

___**Receiving Disability Income** Source: _____

___**Legal Proceeding Pending** Date Suit Filed: _____ Attorney's Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Do you want a report sent to your attorney? ☐ yes ☐ no

___**Report should be sent to referring physician or family physician** ☐ yes ☐ no

Doctor Name: _____

City: _____ State: _____ Zip Code: _____

___**Report should be sent to another party** ☐ yes ☐ no

Name: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Information

In case of an emergency, please contact:

Name: _____ Phone: _____ Relationship: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

The person(s) listed have my approval to access my information:

Name: _____ Relationship: _____ ☐ Medical Information ☐ Financial Information

Name: _____ Relationship: _____ ☐ Medical Information ☐ Financial Information

Signature

☐ I acknowledge that I have been offered a copy of the Office Privacy Notice and I am familiar with my rights as a patient of Dr. Klauer and TMJ & Sleep Therapy Centre. I understand this practice is Fee for Service Out-of-Network and regardless of my insurance coverage, I am responsible for any charges incurred at the time of my visit.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

My signature above certifies that the information listed on this form is accurate and complete to the best of my knowledge.