TruDenta™

HEAD HEALTH HISTORY

PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

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

#	QUESTIONS	ANSWERS		NOTES - LIST QUESTION #, THEN DESCRIBE SYMPTOM DETAILS
1	Have you noticed a change in your bite? » Do you feel like your teeth hit first on the right or left side? ☐ RIGHT ☐ LEFT » Do you hit more on the front teeth or more on the back teeth? ☐ FRONT ☐ BACK	☐ YES	☐ NO	
2	Are you aware of any of the following: Popping/Clicking Grinding Noise in the Jaw Joints	☐ YES ☐ YES ☐ YES	☐ NO ☐ NO ☐ NO	
3	Do you have difficulty or pain ☐ opening wide ☐ chewing?	☐ YES	☐ NO	
4	When you wake up, do your jaw joint or muscles feel tight or sore?	☐ YES	☐ NO	
5	Do you snore at night?	☐ YES	☐ NO	
6	Does your jaw joint or muscles feel stiff, tight or tired after eating?	☐ YES	☐ NO	
7	Do you grind or clench your teeth ☐ at night ☐ during the day?	☐ YES	☐ NO	
8	Do your gums bleed after ☐ brushing ☐ flossing?	☐ YES	☐ NO	
9	Do you experience pain in your: Jaw Face Neck Shoulder and/or Arms	☐ YES ☐ YES ☐ YES ☐ YES	☐ NO ☐ NO ☐ NO ☐ NO	
10	Do you get ☐ headaches ☐ migraines? » How many headaches (H) and migraines (M) each week? _____ (H) /_____ (M) Each month? _____ (H) /_____ (M)	☐ YES	☐ NO	
11	Do you have any ☐ ringing ☐ fullness in your ears?	☐ YES	☐ NO	
12	Do you ever get ☐ dizzy ☐ sea sick?	☐ YES	☐ NO	
13	Do you ever feel ☐ anxiety ☐ stressed? » How would you rate your stress level? ☐ MILD ☐ MODERATE ☐ SEVERE	☐ YES	☐ NO	
14	Have you had braces or orthodontic treatment? » If Yes, when did you finish your treatment? _____	☐ YES	☐ NO	
15	Have you ever worn a ☐ bite splint ☐ retainer? » If Yes, when did you have this treatment? _____	☐ YES	☐ NO	
16	Have you ever had a ☐ car accident ☐ trauma to your head? » If Yes, describe and list dates: _____	☐ YES	☐ NO	
17	Have you ever had any sports injuries? » If Yes, describe and list dates: _____	☐ YES	☐ NO	
18	Do you restrict or avoid normal activities due to pain or symptoms? » If Yes, describe activities: _____	☐ YES	☐ NO	
19	Do you spend 4+ hours in an abnormal postural position daily?	☐ YES	☐ NO	

Scoring: 1-3 "Yes" Responses = Mild unbalanced bite | 4-6 "Yes" Responses = Moderate unbalanced bite | 7+ "Yes" Responses = Severe unbalanced bite

When finished, please return to our office and review your answers with our staff.

TruDenta™

HEADACHE HISTORY

PATIENT INFORMATION

NAME	DATE	AGE	SEX	TELEPHONE
	TODAY / /			

Please review and answer all parts of each question with our staff. Provide specific details/notes in the righthand 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 » ☐ Got worse when _____
4	What other doctors have you seen or tests have you had? _____ _____ _____ _____
5	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: ( )		

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: _____