AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW LISTED REFERRING AND TREATING HEALTH CARE PROFESSIONALS:

Doctors Name	**Location/Phone**

I authorize the release of communications regarding my treatment with ____________________________ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

Signed _______________________________________ Date _____________

Daytime Sleepiness Evaluation

Epworth Sleepiness Scale

The Epworth Sleepiness Scale was developed and validated by Dr. Murray Johns of Melbourne Australia. It is a simple, self-administered questionnaire –widely used by sleep professionals in quantifying the level of daytime sleepiness.

For the following situations, answer with one of the following numbers:

0 - Would never doze

1 - slight chance of dozing

2 - moderate chance of dozing

3 - high chance of dozing

Situation	**Score**
Sitting and reading	
Watching Television	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total Score	

Nighttime Sleepiness Evaluation

Screening Tool for Sleep Apnea

Developed by David White, M.D., Harvard Medical School, Boston, MA

Please answer the following questions.

1.Snoring

a) Do you snore on most night (> 3 nights per week)?

Yes (2) No (0) ______

b) Is your snoring loud? Can it be heard through a door or wall?

Yes (2) No (0) ______

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5) ______

3. What is your collar size?

Male: Less than 17 inches (0) more than 17 inches (5) ______

Female: Less than 16 inches (0) more than 16 inches (5) ______

4. Do you occasionally fall asleep during the day when:

a) You are busy or active?

Yes (2) No (0) ______

b) You are driving or stopped at a light?

Yes (2) No (0) ______

5. Have you had or are you being treated for high blood pressure?

Yes (1) No (0) ______

TOTAL ______

Score

9 points or more	6-8 points	5 points or less
Refer to sleep specialist or order sleep study	Gray area, use clinical judgment	Low probability of sleep apnea

Patient Health Questionnaire

PATIENT INFORMATION

Date of completion

TMNDX™

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

Name: ______________________________
First Middle Initial Last

Age: __________ **Date of Birth:** __________

Referred by: __________ ☐DDS ☐MD ☐ENT ☐DC ☐Other

Location and/or Phone Number of Healthcare Provider: __________

Patient Address: __________ **City:** __________ **State:** ______ **Zip:** ______

Home Phone: __________ **Alternate Contact Number:** __________

Type of Employment: __________

Responsible Party (if different than Patient): __________

Address: __________ **City:** __________ **State:** ______ **Zip:** ______

Family Dentist: __________ **Address and/or Phone:** __________

Family Physician: __________ **Address and/or Phone:** __________

Reason(s) for this appointment: ☐Pain ☐Sleep/Airway ☐Orthodontics ☐Unknown

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU ARE SEEKING TREATMENT IN OUR OFFICE?

NOTE-PLEASE IDENTIFY YOUR CHIEF COMPLAINT AS #1, LIST ALL OTHER SYMPTOMS IN PRIORITY #2-9.

#	Symptom	Recent	Chronic (6 mo.+)
___	Headache pain	☐	☐
___	Ear pain	☐	☐
___	Jaw pain	☐	☐
___	Pain when chewing	☐	☐
___	Facial pain	☐	☐
___	Eye pain	☐	☐
___	Throat pain	☐	☐
___	Neck pain	☐	☐
___	Shoulder pain	☐	☐
___	Back pain	☐	☐
___	Limited ability to open mouth	☐	☐
___	Jaw joint locking	☐	☐
___	Jaw joint noises	☐	☐
___	Ear congestion	☐	☐
___	Sinus congestion	☐	☐
___	Dizziness	☐	☐
___	Tinnitus (ringing in the ears)	☐	☐
___	Muscle twitching	☐	☐
___	Vision problems	☐	☐
___	Kicking or jerking leg repeatedly	☐	☐
___	Swelling in ankles or feet	☐	☐
___	Morning Hoarseness	☐	☐
___	Dry mouth upon waking	☐	☐
___	Fatigue	☐	☐
___	Difficulty falling asleep	☐	☐
___	Tossing and turning frequently	☐	☐
___	Repeated awakening	☐	☐
___	Feeling unrefreshed in the morning	☐	☐
___	Significant daytime drowsiness	☐	☐
___	Frequent heavy snoring	☐	☐
___	Affects sleep of others	☐	☐
___	Gasping when waking	☐	☐
___	Told that "I stop breathing" during sleep	☐	☐
___	Night-time choking spells	☐	☐
___	Unable to tolerate C-Pap	☐	☐
___	Tooth grinding	☐	☐
___	Teeth crowding	☐	☐
___	Other: __________	☐	☐

Do you have concerns in any of these areas: ☐ General Appearance ☐ Ability to Function ☐ Overbite ☐ Smile

Other Comments: __________

Do any of the above complaints or concerns affect your daily life? __________

WHAT ARE THE RESULTS YOU ARE SEEKING FROM TREATMENT?

Patient Signature: __________ Date: __________

© 2006 T&S Therapy Centre International, LLC REPRINT RIGHTS ONLY THROUGH LICENSING. COPY RIGHTS RESERVED

ALLERGIC REACTIONS

Please check any and all medications or substances that have caused an allergic reaction

☐ Anesthetics	☐ Codeine	☐ Penicillin
☐ Antibiotics	☐ Iodine	☐ Plastic
☐ Aspirin	☐ Latex	☐ Sedatives
☐ Barbituates	☐ Metals	☐ Sulfa

Other: ____

CURRENT MEDICATIONS

Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs, etc.

Medication	Dosage	Reason for Taking

☐ See attached list

PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment and/or Medication	Doctor/Provider Name	Approximate Date of Treatment

I release and give my permission for this office to request information and communicate with the providers listed above.

Patient Signature:____ Date:_____________________________________

Parent/Guardian Signature (if patient is a minor): ____ Date: ___________________

HEALTH AND MEDICAL HISTORY

☐Yes ☐ No Are you currently pregnant?

☐Yes ☐ No Have you sustained injury to: ☐Head ☐Neck ☐Face ☐Teeth ☐Other: _______________

☐Yes ☐ No Do you drink 4 or more cups of coffee per day?

☐Yes ☐ No Have you had prior orthodontic treatments?

☐Yes ☐ No Trouble breathing through nose

☐ Yes ☐ No Do you smoke tobacco?

☐ Yes ☐ No Consume alcohol or take sedatives

Patient Signature: ____ **Date:** _______________________

© 2006 T&S Therapy Centre International, LLC REPRINT RIGHTS ONLY THROUGH LICENSING. COPY RIGHTS RESERVED

HEALTH AND MEDICAL HISTORY (CONTINUED)

Do you have, or have you experienced any of the following:

Yes	No	Condition
☐ Yes	☐ No	Heart Disorder/ Heart Attack
☐ Yes	☐ No	Heart Murmur
☐ Yes	☐ No	Mitral Valve prolaps
☐ Yes	☐ No	Heart Pacemaker
☐ Yes	☐ No	Heart Palpitations
☐ Yes	☐ No	Heart Valve Replacement
☐ Yes	☐ No	Irregular Heartbeat
☐ Yes	☐ No	Blood Pressure ☐ High ☐ Low
☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Bleeding Easily
☐ Yes	☐ No	Bruising Easily
☐ Yes	☐ No	Cancer of ________________
		Chemo ☐ Radiation ☐
☐ Yes	☐ No	Anemia
☐ Yes	☐ No	Asthma
☐ Yes	☐ No	Birth Defects
☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Epilepsy
☐ Yes	☐ No	Emphysema
☐ Yes	☐ No	Glaucoma
☐ Yes	☐ No	Gastroesophpgeal Reflex (Gerd)
☐ Yes	☐ No	Hemophilia
☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	History of Substance Abuse
☐ Yes	☐ No	Hypoglycemia
☐ Yes	☐ No	Huntington's Disease
☐ Yes	☐ No	Kidney Disease
☐ Yes	☐ No	Liver Disease
☐ Yes	☐ No	Leukemia
☐ Yes	☐ No	Migraines
☐ Yes	☐ No	Meniere's Disease
☐ Yes	☐ No	Multiple Sclerosis
☐ Yes	☐ No	Muscular Dystrophy
☐ Yes	☐ No	Neuralgia
☐ Yes	☐ No	Osteoarthritis
☐ Yes	☐ No	Osteoporosis
☐ Yes	☐ No	Ovarian Cyst
☐ Yes	☐ No	Parkinson's Disease
☐ Yes	☐ No	Rheumatic Fever
☐ Yes	☐ No	Rheumatoid Arthritis
☐ Yes	☐ No	Scarlet Fever
☐ Yes	☐ No	Thyroid Problem
☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Intestinal Disorder
☐ Yes	☐ No	Nervous System Disorder
☐ Yes	☐ No	Anxiety
☐ Yes	☐ No	Skin Disorder
☐ Yes	☐ No	Urinary Tract Disorder
☐ Yes	☐ No	Chronic Fatigue
☐ Yes	☐ No	Fibromyalgia
☐ Yes	☐ No	Cold hands and feet
☐ Yes	☐ No	Depression
☐ Yes	☐ No	Difficulty concentrating
☐ Yes	☐ No	Difficulty breathing at night for sleep
☐ Yes	☐ No	Dizziness
☐ Yes	☐ No	Excessive Thirst
☐ Yes	☐ No	Fainting
☐ Yes	☐ No	Fluid Retention
☐ Yes	☐ No	Frequent colds/flu
☐ Yes	☐ No	Frequent cough
☐ Yes	☐ No	Frequent ear infections
☐ Yes	☐ No	Frequent sore throat
☐ Yes	☐ No	Frequent awaking at night - number of times _____
☐ Yes	☐ No	Hearing impairment
☐ Yes	☐ No	Memory Loss
☐ Yes	☐ No	Hay Fever
☐ Yes	☐ No	Insomnia
☐ Yes	☐ No	Muscle aches
☐ Yes	☐ No	Muscle fatigue
☐ Yes	☐ No	Muscle spasms
☐ Yes	☐ No	Muscle tremors
☐ Yes	☐ No	Poor circulation
☐ Yes	☐ No	Psychiatric Care
☐ Yes	☐ No	Recent weight gain
☐ Yes	☐ No	Recent weight loss
☐ Yes	☐ No	Sinus problems
☐ Yes	☐ No	Shortness of breath
☐ Yes	☐ No	Slow healing sores
☐ Yes	☐ No	Speech difficulties
☐ Yes	☐ No	Swollen, stiff or painful joints
☐ Yes	☐ No	Tired muscles

Additional Information ____

____

SURGICAL HISTORY *Have you had any of the following:*

Yes	No	Surgery
☐ Yes	☐ No	General Anesthesia
☐ Yes	☐ No	Adenoids removed
☐ Yes	☐ No	Tonsils removed
☐ Yes	☐ No	Jaw Joint Surgery
☐ Yes	☐ No	Orthognathic Surgery
☐ Yes	☐ No	Oral Surgery

Removal of third molar (wisdom teeth) ☐ Other ☐

☐ Yes ☐ No Other surgery ____________________

please list below

Other types of surgery ____

____

____

____

Patient Signature: ______________________________ Date: ________________

© 2006 T&S Therapy Centre International, LLC REPRINT RIGHTS ONLY THROUGH LICENSING. COPY RIGHTS RESERVED

CURRENT SYMPTOMS

Head Pain

Location (L=Left R=Right B=Bilateral)	Recent	Chronic (over 6 mo.)	Severity: Mild	Severity: Mod	Severity: Severe	Duration: Min.	Duration: Hrs.	Duration: Days	Frequency: Occasional	Frequency: Frequent	Frequency: Constant
L☐ R☐ B☐ Frontal (Forehead)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐ Generalized	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐ Parietal (Top of head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐ Occipital (Back of head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L☐ R☐ B☐ Temporal (Temple area)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you have pain or discomfort in any of the following areas? If so, please indicate the approximate date the pain began.

Jaw Pain

☐ L ☐ R Jaw pain with opening
☐ L ☐ R Jaw pain when chewing
☐ L ☐ R Jaw pain at rest

Jaw Joint Sounds

☐ L ☐ R Jaw sounds with opening
☐ L ☐ R Jaw sounds when chewing
☐ L ☐ R Jaw sounds at rest

Jaw Locking

☐ Yes ☐ No Jaw locks closed
☐ Yes ☐ No Jaw locks open

Jaw Joint Symptoms

☐ Yes ☐ No Teeth clenching ☐ Day ☐ Night
☐ Yes ☐ No Teeth grinding ☐ Day ☐ Night

Eye Related Conditions

☐ Yes ☐ No Blurred vision
☐ Yes ☐ No Double vision
☐ Yes ☐ No Eye pain

☐ Yes ☐ No Pain or pressure behind the eyes
☐ Yes ☐ No Extreme sensitivity to light (photophobia)
☐ Yes ☐ No Wear of glasses or contact lenses

Ear Related Conditions

☐ L ☐ R Buzzing in the ears
☐ L ☐ R Ear congestion
☐ L ☐ R Ear pain
☐ L ☐ R Hearing loss
☐ L ☐ R Itchiness or Stuffiness in ears

☐ L ☐ R Pain behind the ear
☐ L ☐ R Pain in front of the ear
☐ L ☐ R Recurrent ear infections
☐ L ☐ R Ringing in the ear (Tinnitus)

Throat Related Conditions

☐ Yes ☐ No Chronic sore throat
☐ Yes ☐ No Difficulty swallowing
☐ Yes ☐ No Swollen glands

☐ Yes ☐ No Thyroid enlargement
☐ Yes ☐ No Tightness in throat
☐ Yes ☐ No Constant feeling of a foreign object in throat

Neck Related Conditions

☐ Yes ☐ No Limited movement of neck
☐ Yes ☐ No Neck pain

☐ Yes ☐ No Numbness in hands or fingers
☐ Yes ☐ No Swelling in the neck

Patient Signature: ______________________________ Date: ________________

© 2006 T&S Therapy Centre International, LLC REPRINT RIGHTS ONLY THROUGH LICENSING. COPY RIGHTS RESERVED

Shoulder Related Conditions

☐Yes ☐No Shoulder pain
☐Yes ☐No Shoulder stiffness
☐Yes ☐No Tingling in hands or fingers

Back Related Conditions

☐Yes ☐No Back pain - lower
☐Yes ☐No Back pain - middle
☐Yes ☐No Back pain - upper
☐Yes ☐No Sciatica
☐Yes ☐No Scoliosis

Mouth and Nose Related Conditions

☐Yes ☐No Dry mouth
☐Yes ☐No Chronic sinusitis
☐Yes ☐No Frequent snoring
☐Yes ☐No Burning tongue
☐Yes ☐No Broken teeth
☐Yes ☐No Frequent biting of the cheek

Sleep Conditions Please select Yes or No answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Positions ☐Side ☐Back ☐Stomach ☐Varies
Is it easy to fall asleep? ☐Yes ☐No
Do you feel rested upon AM waking? ☐Yes ☐No
Stopped breathing during sleep? ☐Yes ☐No
Average hours of sleep per night? ______________________
Do you wake often during the night? ☐Yes ☐No
Gasping or Choking during sleep? ☐Yes ☐No
Have you ever had a Sleep Study (PSG)? ☐Yes ☐No
Result was ____

HISTORY OF SYMPTOMS

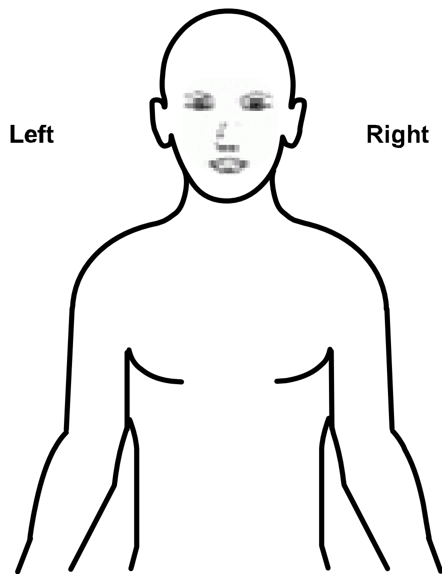
On what date, or approximate date, did this condition or symptoms first occur? ____
☐Yes ☐No **Does any family member have the same or similar problem? If yes, please explain.** ____________________
Can you relate your pain or condition to a motor vehicle accident or traumatic injury? ________________________________
If yes, please complete Trauma History Section, enclosed as a separate form.

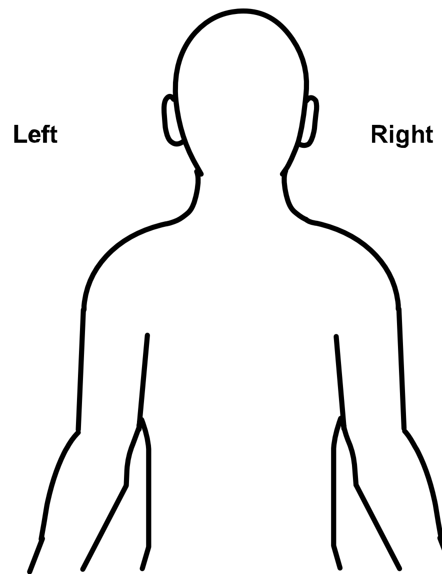
I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

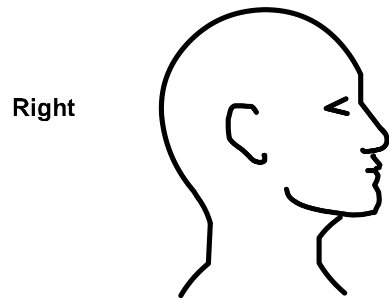
Patient Signature: ______________________________________ Date: ______________________

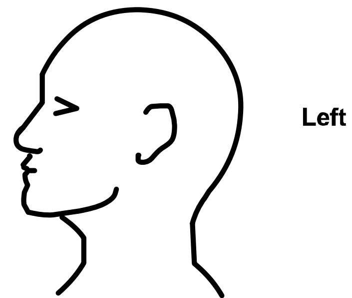
Parent/Guardian Signature (if patient is a minor):______________________________ Date: ____________

© 2006 T&S Therapy Centre International, LLC REPRINT RIGHTS ONLY THROUGH LICENSING. COPY RIGHTS RESERVED









Indicate Areas of Pain
Following the Pain Scale:

1 Mild pain
2 Moderate pain
3 Severe pain