Certified Specialists in Orthodontics

Dr. Leagh Harfield
Dr. Michael French

Date: ______________________

Patients Name: ___________________________ _____________________ ________
Last First init.

Address: ____

_____________________________ , ________ _______________
City Prov. Postal Code

Phone No.: ________-_________ (home) ________-__________ (work) ________-_________(cell)

e-mail: ____

Date of Birth: ______ ______ ______ Age: ________ Gender: [ ]Male [ ]Female
Mth Day Year

Occupation: _____________________________________

Who referred you to our office? ____

Name of General Dentist: ___________________________ last visit: _____________

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1. What is the main concern that brings you to our office?

____

2. When did your concern originate? ____

3. How did your concern begin?
(check all those that apply)

	Jaw surgery		Tooth extraction
	Motor vehicle accident		Stress
	Chewing		Nothing; pain just came on
	Trauma to jaw/head/neck		Other:___________________________
	Extensive dental work		________________________________

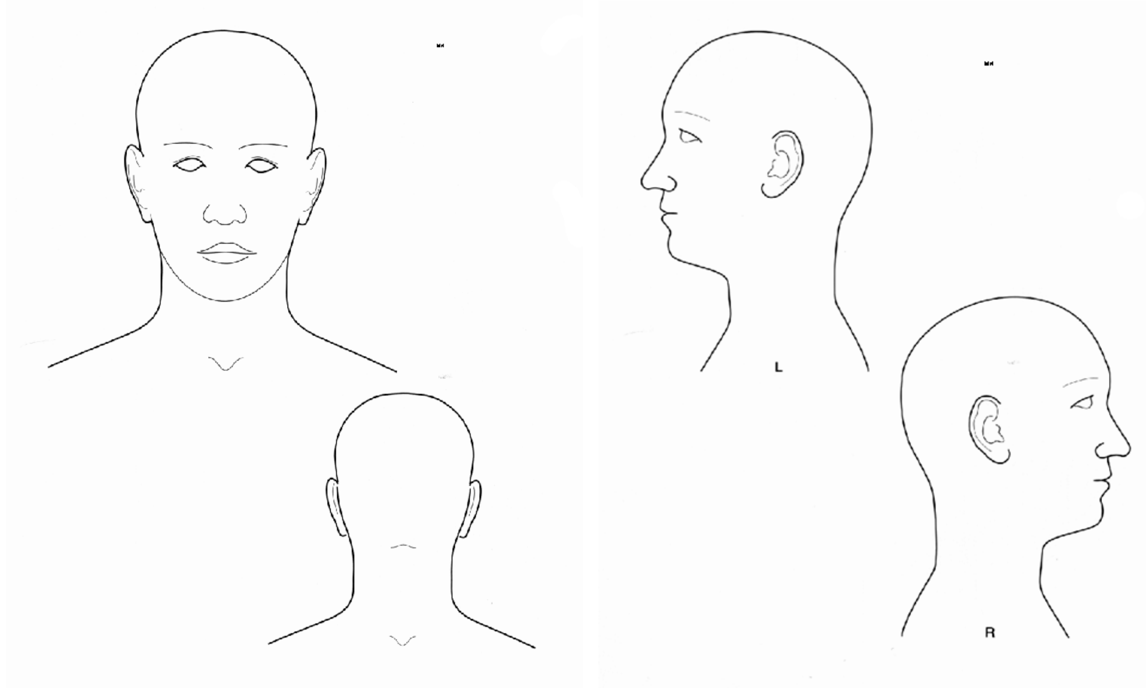
4. What is the usual severity of your pain? (place an "x" on the line)

0 1 2 3 4 5 6 7 8 9 10
(no pain) (extreme pain)

5. Describe the way your pain typically feels:
(check all those that are appropriate)

	Throbbing		Gnawing		Splitting
	Shooting		Hot/burning		Tiring
	Stabbing		Aching		Sickening
	Sharp		Heavy		Fearful
	Cramping		Tender		Punishing

6. On the diagrams below please outline the areas where you feel pain:



7. How long does the pain typically last?

	Less than 1 minute		6-12 hours
	1-10 minutes		13-24 hours
	Less than 1 hour		Several days
	1-5 hours		Constant

8. Which of the following causes or aggravates the pain?

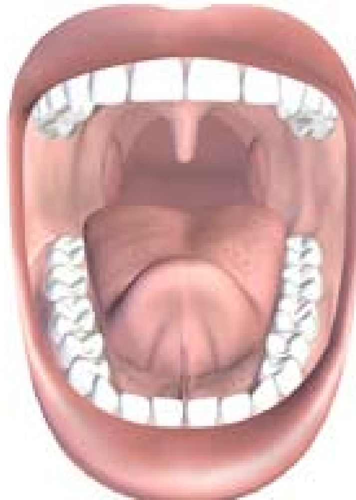
	Chewing		Opening mouth wide		Hot or cold drinks
	Talking		Lack of sleep		Damp or cold weather
	Yawning		Playing instrument		Stress/emotional upset
	Laughing		Sitting for long periods		Exercise
	Singing		Eating certain foods		Other: _______________

9. Which of the following relieves the pain?

	Exercise		Massage		Ice/cold compresses
	Heat		Changing jaw position		Pain medication
	Sleep		Relaxation		Nothing helps
	Time		Warm soak/compresses		Other: _______________

10. Do you have any painful teeth or other painful areas in your mouth? [ ]yes [ ] no

(If yes, please indicate the area on the diagram)



11. Check any of the following that you experience:

	Numbness in the face or jaw		Weakness in jaw muscles
	Earaches		Ringing or buzzing in the ears
	Ear stuffiness		Dizziness
	Neck pain		Pain in back of head
	Back pain		Morning stiffness
	Easily fatiqued		Jaw locking
	Aches and pains all over body		Decreased ability to open
	Numbness/tingling in hands or fingers		Clicking/popping in jaw joints

12. Are you bothered by headaches? [ ]Yes [ ] No (If no, skip to question #13)
(If yes, continue on)

a) On average, how painful are your headaches?

0 1 2 3 4 5 6 7 8 9 10
(no pain) (extreme pain)

b) Do you have headaches as often as once per week? [ ]Yes [ ]No
c) Do you have more than one type of headache? [ ]Yes [ ]No
d) Do you wake in the morning with a headache? [ ]Yes [ ]No
e) Do you have headaches later in the day? [ ]Yes [ ]No
f) Do headaches wake you up from a sleep? [ ]Yes [ ]No
g) Is there any nausea or vomiting associated with your headaches?[ ]Yes [ ]No

h) Are there vision changes associated with your headaches? [ ]Yes [ ]No
if yes, describe: ____
____

(question continued on following page)

i) What relieves your headaches?

	Resting		Nothing
	Sleeping		Pain medications: ________________________
	Exercise		____

13. Have you been in an accident or received a "blow" or injury to any part of your face, head, neck or back? [ ]Yes [ ]No

If yes, when? ____
Describe:
____

14. Are you aware of your jaw making sounds? [ ]Yes [ ]No (If no, go to question #15)
(If yes, continue on)

a) Which side? [ ]right [ ]left [ ]both
b)What is the nature of the sound(s):

	Clicking		Cracking
	Grating		Wetness
	popping		Other: ____________________

c)When do you notice the sounds?

	Early opening		Moving jaw side to side
	Middle opening		Chewing
	Wide opening		While closing

d) Is the sound always present? [ ]Yes [ ]No
e) Do you feel the sounds are related to your pain? [ ]Yes [ ]No

15. Has your jaw ever locked open? [ ]Yes [ ]No
[ ]right side [ ]left side [ ]both sides

Date of first occurrence: ____
Was treatment sought? [ ]Yes [ ]No If yes, by whom: ____________________________
____

16. Has your jaw ever locked closed or partially closed? [ ]Yes [ ]No
[ ]right side [ ]left side [ ]both sides

17. How many times has your jaw locked open or closed during the past year?
[ ]none or # of times: __________

18. Do you have pain when your jaw locks open or closed? [ ]Yes [ ]No [ ]n/a

19. Do you chew gum? [ ]frequently [ ]sometimes [ ]rarely [ ]never

20. Have you noticed any other oral habits or practices that aggravate or cause pain?

	Clenching of the teeth		Chewing finger nails
	Chewing ice		Cheek/lip biting
	Chewing pencils/pens		Playing instruments
	Holding phone		Other: ____________________________
	Grinding the teeth		___________________________________

21.Check all of the following that apply to you:

	Feel under stress much of the time		Feel light-headed or dizzy
	Stress makes the pain worse		Hand and feet are often cold/hard to warm
	Do not enjoy my job		Under the care of a physician
	Pain prevents me from enjoying normal activities		There are times I feel as though I cannot breathe in enough air
	Feel depressed much of the time		Under the care of a psychiatrist/psychologist

22.Check all of the following that apply to you:

	Do not sleep well		Vivid dreams or nightmares
	The pain interferes with sleep		Go to bed more tired than daily activities justify
	Awaken frequently during the night		Do not feel rested in the morning
	Restless sleeper		Other: ____________________________________

23. Do you feel that you usually eat a healthy, balance diet? [ ]Yes [ ]No

24. For each of the beverage listed below, write in the average number that you will drink each day:

Natural coffee		cups/day	Alcoholic beverages		drinks/day
Decaffeinated coffee		cups/day	Soft drinks		cans/day
Natural Tea		cups/day	Energy drinks		cans/day
Decaffeinated Tea		cups/day	Other: ______________		_____/day

25. What types of health care providers have you seen for your problem?

	None		Rheumatologist		General dentist
	Rehabilitation medicine		Physical medicine		Oral surgeon
	Pain clinic		Anaesthesiologist		Orthodontist
	TMJ specialist		Family physician		Ophthalmologist
	Internist		Osteopathic physician		Chiropractor
	ENT Physician		Neurologist		Neurosurgeon
	Orthopaedic surgeon		Physical therapist		Naturopath

26. Please list names of the health care providers indicated above:

____

____

____

____

____

27. Which of the following treatment(s) have you received for your pain?

	Traction		Splints or bite planes		Electrical stimulation
	Injections		Counselling		Ultrasound/iontophoresis
	Acupuncture		Medications		Dental treatment
	Massage		Heat/cold application		Exercise
	Nerve blocks		Acupressure		Bite adjustments
	Biofeedback		Stress management		TMJ surgery
	Pain program		Drug/alcohol rehab		Orthodontics/braces
	Hypnosis		Chiropractic treatment		Other: _______________

28. Which tests have you had for the problem?

	X-rays		Myelogram		Tooth pulp test
	EMG		MR scan		Urine studies
	Venogram		Arteriogram		Blood studies
	Joint arthrogram		Nerve block		CT scan
	TMJ x-rays		Diet analysis		Thermogram
	Allergy testing		Other: ____		

29. Do you smoke? [ ]Yes [ ]No If so, how much? ________ packs/day

General Health Questionnaire

1. Name of Physician: ____
   Phone No.: ___________- ______________
   Date of last appointment: __________________________
   Are you currently under their care for any reason? [ ]Yes [ ]No
   If yes, why? ____

2. Are you taking (or supposed to be taking) any medicine, drugs, or pills of any kind?
   [ ]Yes [ ]No
   If yes, what kind and dose? ____
____
____

3. Do you have reactions or allergies to drugs or medicines? [ ]Yes [ ]No
If yes, which ones?
____
____
____

4. Have you had an adverse reaction to dental or general anaesthetic? [ ]Yes [ ]No
If yes, describe:
____

5. Have you ever had any operations or surgery? [ ]Yes [ ]No
If yes, please list:
____
____
____

6. When you walk up stairs or take a walk, do you ever have to stop due to pain in your chest, shortness of breath, or because you are very tired? [ ]Yes [ ]No

7. Do your ankles swell during the day? [ ]Yes [ ]No

8. Have you unintentionally lost or gained more than 10 lbs in the past year? [ ]Yes [ ]No

9. Are you on a special diet? [ ]Yes [ ]No

10. (WOMEN) Are you pregnant or suspect to be pregnant? [ ]Yes [ ]No

Please check the box for any condition which you have had in the past or have now.

1	**Cardiovascular**	3	**Neurologic**	5	**Pulmonary**
	Congestive heart failure		Vision problems		Hay fever
	Heart attack		Glaucoma		Sinus trouble
	Angina Pectoris/chest pain		Earaches/ringing in the ears		Allergies or hives
	High blood pressure		Hearing loss		Asthma
	Heart murmur		Severe headaches		Chronic cough
	Mitral Valve Prolapse		Fainting or dizzy spells		Emphysema
	Rheumatic fever		Stroke		Chronic bronchitis
	Congenital heart defect		Epilepsy or seizures		Tuberculosis
	Artificial heart valve		Psychiatric treatment		Breathing difficulties
	Arrhythmias		Panic attacks		Sarcoidosis
	Pacemaker/defibrillator		Phobias	6	**Dermal/Musculoskeletal**
	Coronary by-pass	4	**Gastrointestinal**		Allergy to latex (rubber)
	Coronary angioplasty		Ulcers		Skin rash
	Heart transplant		Colitis		Recent changes in moles
	Aneurysm		Irritable bowel syndrome		Osteoarthritis
	Other heart concerns		Persistant diarrhea		Rheumatoid Arthritis
2	**Hematologic**		Hepatitis		Systemic Lupus
	Blood transfusion		Liver disease		Artificial joint (prosthetic)
	Anemia		Yellow jaundice		Fibromyalgia
	Hemophilia		Cirrhosis		Chronic fatigue syndrome
	Leukemia		Eating disorder		Scleroderma
	Sickle cell anemia		Gastric acid reflux		Sjogren’s syndrome
	Tendency to bleed longer				CRPS 1 (RSD) or CRPS II (Causalgia)

7	**Endocrine**	9	**Other Conditions**
	Diabetes		Anxiety disorder
	Thyroid disease		Depression
	Takes cortisone or other steroids		Frequent sore throats
	Hormone replacement therapy		Enlarged lymph node or “gland”
8	**Genitourinary**		Use tobacco
	Urinate frequently		Use alcohol
	Kidney/bladder problem		Use injectable drugs
	Dialysis		Tumor or cancer
	Kidney transplant		Radiation therapy
	Sexually transmitted disease (Syphilis, Gonorrhea, Chlamydia, genital herpes)		Drug or alcohol addiction (currect or recovering)
	HIV positive		Chemotherapy
	Interstitial cystitis		Sleep apnea
	endometriosis		Snoring

Disease, problem or condition not listed:

____

____

INSURANCE INFORMATION

Subscriber ____________________________ 2)____________________________
Insurance Co. ____________________________ ____________________________
Group/Policy ____________________________ ____________________________
I.D./Cert. No. ____________________________ ____________________________
Date of Birth ____________________________ ____________________________

ACCOUNTING INFORMATION

Person responsible for payment of account *if different from patient*:

Name: ____________________________ ______________________ ________________
Last first relationship

Phone No. ________ - ___________ (home) _________-__________ (work/cell)

Address: ______________________________________
____
____
____

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Answers to all questions are true and complete to the best of my knowledge

Date: ___________________________ Signature: ______________________________

Financing with Dr. Leagh Harfield Professional Corporation, Dr. Michael French Professional Corporation, or HarFrench Management Corporation is available upon approved credit. I understand and consent to such pre-approval when and if payment plans are arranged.

Date: __________________________ Signature: ________________________________

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