The Bell Center

For High Level Wellness & Vibrant Good Looks

Today's Date: ____/____/____

TMJ Diagnostic & Treatment Patient Information

Adult / Patient: _____Prefer to be called: _____

Child / Patient: _____ Prefer to be called: _____

Emergency contact: _____ Emergency Contact No: _____

Address:_____
Street City State Zip

Date of birth: ____/____/____ Age: _____ Social Security No: _____-____-_____
Marital Status:_____
Home No: _____ Work No: _____
Cell No: _____
Email:_____

Whom may we thank for referring you to us? _____

What prompted you to seek TMJ diagnostic and treatment care at this time? **Label 1 – 10 (1 being the most important complaint, 2 the second most important, 3 the third most, etc., 10 the least important.)**

____ Back Pain	____ Jaw Clicking	____ Neck Pain
____ Dizziness	____ Jaw Joint Noises	____ Pain when Chewing
____ Ear Congestion	____ Jaw Locking	____ Ringing in the Ears
____ Ear Pain	____ Jaw Pain	____ Shoulder Pain
____ Eye Pain	____ Limited Mouth Opening	____ Sinus Congestion
____ Facial Pain	____ Muscle Soreness	____ Throat Pain
____ Fatigue	____ Muscle Twitching	____ Tinnitus
____ Headaches		____ Visual Disturbances

Please list treatment you have had for TMJ problems and all health professionals that you are currently seeing. Please include all surgeries, even if you believe they are unrelated to TMJ:

Practitioner Specialty Treatment & Approx. Date

1) _____

2) _____

3) _____

4) _____

5) _____

When did you last have Full Mouth x-rays taken?_____
Do you take nutritional supplements or vitamins? Yes No
If yes, what are you taking? _____
_____

Did you eat breakfast this morning? Yes No

What did you eat?_____

Have you ever had any teeth removed? Yes No

If yes, reason:_____

Do you mostly mouth breath during the day or while sleeping? Yes No

Do you ever have difficulty swallowing food or liquids? Yes No

Do you smoke? Yes No

If yes, how much per day?__ _____

Do you gag easily while in the dental chair? Yes No

Are your teeth sensitive to hot, cold, sweets, chewing or biting? Yes No

How often do you brush your teeth each day and for how many minutes?

_____

Symptoms

Head Pain Location Severity Frequency Duration

L	R	B	Front of your head (Frontal)	Mild	Mod.	Severe	Occ.	Freq.	Constant	Sec	Min	Hrs	Days	Wks
L	R	B	Entire head (Generalized)	Mild	Mod.	Severe	Occ.	Freq.	Constant	Sec	Min	Hrs	Days	Wks
L	R	B	Top of your head (Parietal)	Mild	Mod.	Severe	Occ.	Freq.	Constant	Sec	Min	Hrs	Days	Wks
L	R	B	Back of your head (Occipital)	Mild	Mod.	Severe	Occ.	Freq.	Constant	Sec	Min	Hrs	Days	Wks
L	R	B	In your temples (Temporal)	Mild	Mod.	Severe	Occ.	Freq.	Constant	Sec	Min	Hrs	Days	Wks

L= Left R= Right B=Bilateral

I have read and understand the preceding information. I have answered the questions correctly and honestly to the best of my recollection and ability.

Signature of patient or Guardian: _____**Date**_____

Witness or Treatment Coordinator for Michael Bell, DDS:_____**Date:**_____

The Bell Center for Biological Dentistry

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Discomfort History

Head, Neck and Back Pain Symptoms			
Do you get tension or migraine Headaches?	Yes	No	If so, where, when and how often?
_____			
Do you frequently have a stiff neck?	Yes	No	If so, how often?_____
Do you have trouble sleeping soundly at night?	Yes	No	Daily, once a week, once a month?
Do you take anything to help you sleep better?_____			
Do you have shoulder discomfort?	Yes	No	
Do you take pain medication?	Yes	No	Please list all and how often: _____
_____			
Do your hands, wrists or arms ache?	Yes	No	
Jaw Joint Symptoms			
Do your teeth ever feel sore after awakening?	Yes	No	
Do you grind your teeth at night?	Yes	No	
Does your jaw ache when you chew?	Yes	No	
Do you have a family history of TMJ problems?	Yes	No	
Does your jaw hurt when you open really wide?	Yes	No	
Does your jaw ever lock?	Yes	No	
Any clicking, popping or cracking in the jaw joint?	Yes	No	
Any discomfort in the jaw joint?	Yes	No	
Ear & Eye Symptoms			
Do you have ear discomfort?	Yes	No	
Do you hear grating noises in your ears while chewing?	Yes	No	
Do you have ringing, buzzing or hissing in ears?	Yes	No	
Do you have itchiness or stuffiness in either ear?	Yes	No	
Do you suffer from loss of hearing?	Yes	No	
Do you get pain in or around the eyes?	Yes	No	
Are there times when your eye sight blurs?	Yes	No	
Do you wear contacts or glasses?	Yes	No	
Trauma or Accidents			
Have you ever had a severe blow to the jaw or head?	Yes	No	Explain: _____
_____			
Have you been involved in any accidents?	Yes	No	Explain: _____
_____			
Any whiplash injuries?	Yes	No	Explain: _____
_____			
Do you get dizzy or faint?	Yes	No	How often? _____
Do you ever experience motion sickness?	Yes	No	
Breathing			
Do you have any allergies?	Yes	No	To what? _____
Do you have any sinus problems?	Yes	No	
Do you snore at night?	Yes	No	
Is your nose stuffed up even without a cold?	Yes	No	

Name: _____ Date: _____

Signature of Patient of Guardian:

_____

Patient Health History

Approx. date of last physical exam: _____

Has there been any change in your health in the last 5 years?_____

_____

_____

Are you under the care of a physician, chiropractor or psychologist? Yes No

Name(s) of provider:_____

If so, what condition(s) are you being treated for? _____

_____

Have you had a serious illness, injury or operation in the past 5 years?Yes No

If so, what? _____

Do you have any of the following presently or in the past? Please circle all that apply:

Abscesses	Acquired Immune Deficiency	Anemia	Allergies
Arthritis	Artificial prosthesis	Asthma or Hay fever	Blood Diseases
Bruise Easily	Bulimic	Cancer	Chronic Pain
Cortisone Medication	Diabetes	Emphysema	Epilepsy
Excessive Bleeding	Fainting spells	Glaucoma	Gum Disease
Head injury	Heart Disease	Heart Murmur	Hepatitis
Herpes	H/L Blood Pressure	Implants	Jaundice
Heart valve replacement	Kidney disease	Liver disease	Mitral Valve Prolapse
Neck pain or injury	Nervous disorders	Transplants	Pacemaker
Pregnancies / Pregnant	Cancer Treatment	Respiratory disease	Rheumatic fever
Seizures	Sinus trouble	Spinal cord injury	Stomach Ulcers
Stroke	Thyroid disease	TMJ / TMD	Tooth Extractions
Tuberculosis	Tumors or Growths	Venereal Disease	

Others:_____

Are you taking any medications presently? Yes No

Please list medications if any.

_____

_____

Are you allergic to any medications: Yes No

Penicillin

Codeine

Sulfa

Novocain

Other:

_____

Is there anything else we should know about your health?

_____

_____

Signature of Patient or Guardian:

_____

Date: _____