Full name:_____ DOB:_____

Address:_____

Phone Number_____ Email:_____

Reason for visit please check all that apply:

__ TMJ pain

__ Locked / Clicking/ Popping Jaw

__ Limited movement/ Opening

__ Ear pain

__Head/Neck/ Shoulder pain

__ Headaches

__ Clenching/ Grinding teeth

Have you had trauma to the head/neck or TMJ? __Yes __ No

If yes, please describe:

_____

_____

Please describe your pain as **Acute** (present for less than a week) or **Chronic** (present for more than a week) (**Circle**)

Do you wear an oral device? (Night guard, sleep apnea guard) __ Yes __No

Have you been seen and or treated for this pain? __ Yes __ No

If yes, please describe with most recent date of treatment:

_____

_____