Utah Jaw Pain Clinic

James L. Guinn, D.M.D.

Practice Limited to Jaw Disorders
6287 S. Redwood Rd, Suite 101
Salt Lake City, UT 84123
801-261-9155

PATIENT INFORMATION

INSTRUCTIONS: Please answer all questions as accurately and thoroughly as possible. The completeness of your answers directly affects the diagnostic decisions made on your behalf. Although some questions may not seem applicable to you, there is a specific reason for each question asked. This information will remain confidential at all times. We realize that it will take considerable time to complete this form. We can assure you this information will be reviewed in detail before, during, and after your examination.

GENERAL INFORMATION (Please Print)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone:_____ Work Phone:_____

Home Phone: _____ Email:_____

Age:_____ Birth date:_____ Social Security Number_____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Occupation: _____Employed By: _____

Dental Insurance Name: _____ Member ID #:_____

Medical Insurance Name_____ Member ID #_____

Name of Policy Holder: _____ Birth date:_____

Name of Spouse: _____Occupation: _____

If Patient is a Minor, Parent's Names: _____

Address, phone, if different than above: _____

Emergency Contact Person: _____Phone:_____

Who referred you to our office? _____

If this individual is a doctor or therapist, please indicate his/her field or specialty:_____

Address_____ Phone: _____

SYMPTOM HISTORY

What are your specific symptoms? Please list all symptoms or problems which are causing you concern. Please rank these problems in order of concern to you, with the problem of greatest concern first, the problem of least concern last.

	Problem	Onset When did you first Notice this problem?	Frequency How often does it occur?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Are any of the above problems the result of an accident or injury? ☐ YES ☐ NO

If YES please continue below, if NO please skip to page 3.

Date of incident _____

Describe briefly how the accident or injury occurred:_____

_____

_____

_____

_____

_____

How soon after this incident did the symptoms start? _____

Describe your physical injuries at the time (i.e., what parts of your body were hurt).

_____

_____

_____

_____

Did any part of your body receive a direct blow? ☐ YES ☐ NO If Yes, which parts?

_____

_____

_____

_____

PHYSICIAN / DENTIST INFORMATION

General Dentist: _____

Address _____ Phone _____

Personal Physician _____ Phone _____

Address _____

PREVIOUS TREATMENT

Please list all Physicians, Dentists, Chiropractors, Physical Therapists, Pain Centers, or other therapists who have been involved in diagnosing or treating you for these problems. Please list in chronological order, if possible. Include the individual's name, specialty, and phone number.

_____

_____

_____

_____

_____

_____

_____

_____

Of those listed above, who helped you the most? _____

Realizing that you are visiting this office for diagnosis and/or treatment of your problem, do you have an opinion about what should be done to correct these problems?

_____

_____

PREVIOUS TRAUMA

Please list **any** injuries to your head, jaw, face or neck, including when you were a youngster.

Date

_____ _____

_____ _____

_____ _____

_____ _____

Please list your most serious illness or injuries **not** included above.

_____ _____

_____ _____

Have you ever been physically abused or battered? Yes No

MEDICAL HISTORY

Height_____ Weight _____

Please circle YES or NO. If YES, Please fill in details.

YES NO Have you had rheumatic fever? When? _____

YES NO Do you have high or low blood pressure? Is it controlled? _____

YES NO Have you ever had diabetes or hypoglycemia? How is it controlled? _____

YES NO Are you allergic to (or been advised not to take) any medication or food? What? _____

_____

YES NO Have you ever had hepatitis? When? _____

YES NO Have you ever been told you are H.I.V. Positive? When?_____

YES NO Have you ever been told you have AIDS or AIDS-Related Complex? When? _____

YES NO Have you ever had a tumor or cancer? How was it treated?_____

YES NO Have you gained or lost weight within the last year? Gained _____ Lost _____ pounds

YES NO Is your diet medically supervised? For what purpose? _____

YES NO Do you have problems with other joints, such as knees, ankles, wrists, etc.? _____

YES NO Have you been told, or do you suspect, you have Chronic Fatigue Syndrome or Fibromyalgia?

Operation History

Please list all operations you have had.

	Date
_____	_____
_____	_____
_____	_____
_____	_____

Sleep History

How many hours of sound sleep do you get on average? _____

Yes No Do you have difficulty falling asleep?

Yes No Do you feel you need more sleep than you are getting?

Yes No Do you often wake up feeling tired, fatigued, or worn out?

What position do you usually sleep in when you are in bed?

_____

Nutritional History

How do you feel about the quality of your diet? Place an "X" on the line below to indicate your answer.

_____

Extremely Healthy — Extremely Poor

Do you usually eat:	YES	NO
Breakfast	☐	☐
Lunch	☐	☐
Dinner	☐	☐
Between meals	☐	☐
Before bed	☐	☐

Have you ever had an eating disorder? Yes No

If yes, did this include repeated vomiting? Yes No

Have you ever been addicted to drugs or alcohol? Yes No

How often do you chew gum? _____

MEDICATIONS USED

Please list the names of ALL medications you presently take, including non-prescription drugs. Also, please indicate the purpose for which you are taking each.

_____ For _____

_____ For _____

_____ For _____

_____ For _____

_____ For _____

_____ For _____

_____ For _____

_____ For _____

_____ For _____

_____ For _____

Have you ever regularly taken any of the following types of medications?

NOW	PAST	NO	
☐	☐	☐	Anti-Depressants
☐	☐	☐	Anti-Anxiety Agents
☐	☐	☐	Sleeping Aids
☐	☐	☐	Muscle relaxants
☐	☐	☐	Prescription pain relievers
☐	☐	☐	Steroids, i.e., Cortisone
☐	☐	☐	Non-steroidal anti-inflammatory
☐	☐	☐	Insulin
☐	☐	☐	Sinus/Allergy
☐	☐	☐	Blood pressure
☐	☐	☐	Other _____

EMOTIONAL STRESS

Please answer the following questions as honestly as possible. Circle the "Yes" answer if the statement describes you most of the time.

Yes No I am unable to relax

Yes No I feel anxious, nervous, or tense

Yes No I feel scared

Yes No I am afraid of losing control

Yes No I don't have enough time for myself

Yes No I'm a perfectionist

Yes No My thoughts are full of fear and worry

Yes No I experience difficulty breathing

Yes No I feel hot, faint, flushed, or unsteady

Yes No I am restless and can't keep still.

Yes No I feel numbness, tingling, or shaky

Yes No I feel overwhelmed

Yes No I feel downhearted or sad

Yes No I don't enjoy the things that I used to do

Yes No I have thoughts of killing myself

Yes No I feel that I am not useful or needed.

Yes No My mind isn't as clear as it used to be

Yes No I get tired for no reason

Yes No I feel discouraged about the future.

Yes No I feel like a failure

Yes No I find it difficult to make decisions

Yes No I am dissatisfied or bored with life

Yes No It is difficult to get my work done

Yes No I have lost interest in other people

FOR WOMEN ONLY:

Yes No Are you pregnant? Expected delivery date? _____

Yes No Do you have children? How many? _____

Yes No If yes, did you experience frequent vomiting during your pregnancy(s)

Yes No Have you taken birth control pills for more than 6 months? Are you currently taking them? Y N

Yes No Do you frequently miss menstrual periods? Reached menopause or had a hysterectomy? Y N

SYMPTOM SURVEY

Please answer the following questions. If your answer to each question is "NOW" or "PAST," please fill in details where indicated. Also, please indicate which side of your body the condition occurs on.

NOW PAST NO

☐ ☐ ☐ Do you have frequent pain? How Often? _____

What is the intensity of your pain? ☐ Mild ☐ Moderate ☐ Severe

What medications do you take for the pain? _____

****If you are having pain, please complete pain diagrams on the back of this form.**

☐ ☐ ☐ Have you ever heard or felt popping, clicking, or cracking upon opening or closing your mouth?

☐ Right ☐ Left ☐ Both

When did you first notice this? _____

Do you currently have this condition? ☐ YES ☐ NO

How frequently does it occur? _____

Did it start after any particular event? _____

Is/Was there pain associated with this noise? ☐ YES ☐ NO

☐ ☐ ☐ Has there ever been a time when your jaw caught or locked, so that you could not open?

☐ Right ☐ Left ☐ Both

Does your jaw presently feel locked? ☐ YES ☐ NO

How many times has it occurred? _____

When was the last time it occurred? _____

☐ ☐ ☐ Has there ever been a time when your jaw caught or locked, so that you could not close?

☐ Right ☐ Left ☐ Both

How many times has this occurred? _____

☐ ☐ ☐ Do you have to move your jaw sideways in order to open your mouth?

☐ ☐ ☐ Does your jaw feel tight or restricted when opening?

☐ Right ☐ Left ☐ Both

☐ ☐ ☐ Does opening your mouth or chewing cause jaw pain?

☐ ☐ ☐ Does your jaw swing to one side when you open wide? ☐ Right ☐ Left

☐ ☐ ☐ Do you have pain in your jaw without movement or function? ☐ Right ☐ Left ☐ Both

☐ ☐ ☐ Do you ever awaken with a feeling of tiredness or fatigue in your jaw muscles?

☐ ☐ ☐ Do you hear grating or gravel-like sounds in your ears or jaw joints? ☐ Right ☐ Left ☐ Both

☐ ☐ ☐ Have you been told you have arthritis? When? _____

Which joints are affected? _____

☐ ☐ ☐ Do you have weak ligaments in your joints, or ever been told you are "double-jointed?"

Now Past No

☐ ☐ ☐ Are you ever aware of clenching or grinding your teeth?

☐ ☐ ☐ Does your bite feel uncomfortable or uneven to you?

☐ ☐ ☐ Are there times when you can not get your back teeth together?

☐ ☐ ☐ Have you had orthodontic treatment (braces)? Age during treatment: _____

What was your orthodontist's name? _____

☐ ☐ ☐ Have you ever had your teeth ground on to improve your bite?

☐ ☐ ☐ Have you ever worn a bite guard? For how long? _____

☐ ☐ ☐ Are your teeth painful, sensitive, or does it hurt to bite on them?

☐ ☐ ☐ Do you ever have a burning sensation in your mouth?

☐ ☐ ☐ Do you ever get sharp or shooting pains in your face? ☐ Right ☐ Left ☐ Both

☐ ☐ ☐ Does your face ever feel swollen? ☐ Right ☐ Left ☐ Both

☐ ☐ ☐ Do you have frequent headaches (more than 2 per week)?

How often do they occur? _____

How long have you been having them? _____

What time of day do they usually start? _____

Please indicate if they are accompanied by any of the following:

☐ Neck pain ☐ Jaw pain ☐ Muscle tension ☐ Emotional Stress

☐ ☐ ☐ Do you frequently have neck pain or stiff neck muscles? ☐ Right ☐ Left ☐ Both

☐ ☐ ☐ Do you frequently have pain in your shoulders or upper back? ☐ Right ☐ Left ☐ Both

☐ ☐ ☐ Do you experience numbness in your arms or hands? ☐ Right ☐ Left ☐ Both

☐ ☐ ☐ Do you experience pain radiating down your arms or hands? ☐ Right ☐ Left ☐ Both

☐ ☐ ☐ Do you get low back pain?

☐ ☐ ☐ Do you have ear problems?

☐ Ear pain ☐ Right ☐ Left ☐ Both
☐ Ringing or buzzing noises ☐ Right ☐ Left ☐ Both
☐ Congestion or pressure in ears ☐ Right ☐ Left ☐ Both
☐ Hearing loss ☐ Right ☐ Left ☐ Both
☐ Grating, cracking, or popping sounds ☐ Right ☐ Left ☐ Both

☐ ☐ ☐ Do you have periods of dizziness, or loss of balance or equilibrium?

☐ ☐ ☐ Do you feel pain or pressure behind or above your eyes? ☐ Right ☐ Left ☐ Both

☐ ☐ ☐ Do any of these problems disrupt the quality of your life? If yes, please explain.

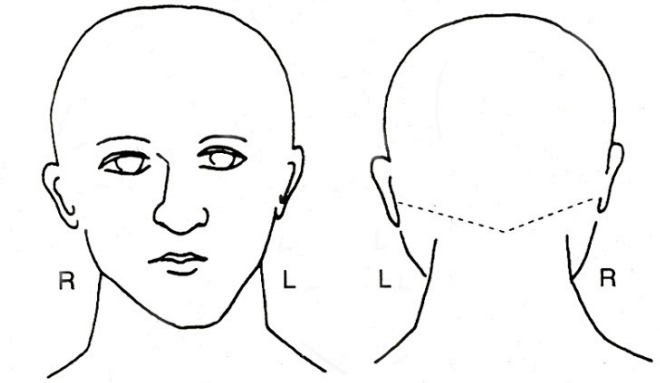
_____

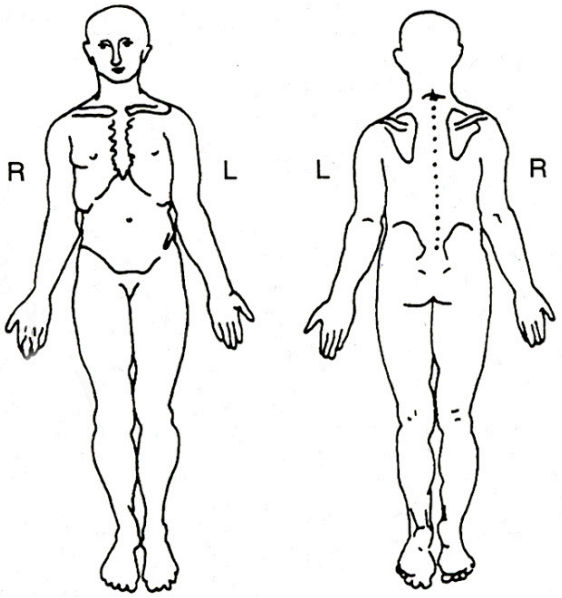
_____

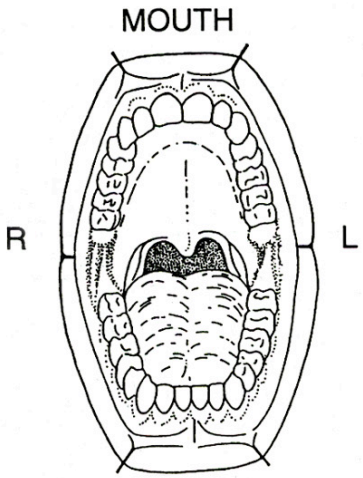
_____

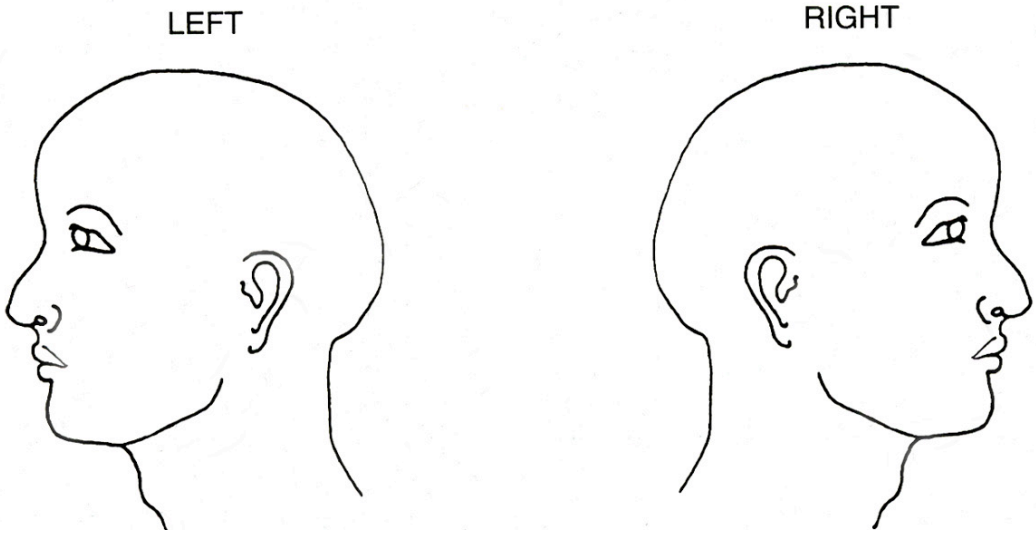
_____

If you have frequent pain, please mark the location of your pain on each diagram that applies. Use an “X” to mark the locations of your pain. Circle the X in the location where you have the greatest pain.









I, the undersigned (patient or legally responsible party), assume financial responsibility for services rendered. It is understood that Dr. Guinn is required by law to retain all original x-rays, records, and models taken in this office. Copies of these records may be obtained for an additional fee. I agree to pay 1 1/2% interest per month on any unpaid balance. If my account becomes delinquent, I agree to pay a 50% collection fee on the amount owing.

Signature _____ Date _____

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