Head, Neck and Face Intake Questionaire

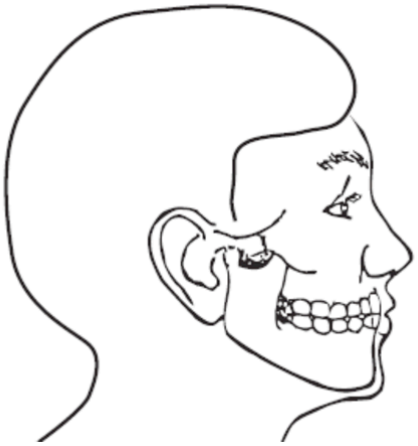
Name: _____ Date: _____
Referred By: _____ Current dentist: _____

If you have any of the following symptoms, please indicate the area(s) involved:
Please mark with a star (*) any areas that routinely cause you discomfort

HEAD
1. Tension Headaches R L
2. Migraines R L
3. Chronic Headaches R L
4. Tender to Touch R L

EAR
1. Clogged R L
2. Ear Pain R L
3. Ringing, Buzzing R L
4. Dizziness R L

JAW
1. Clicks, Pops R L
2. Joint Pain R L
3. Grinding Noise R L
4. Facial Pain R L

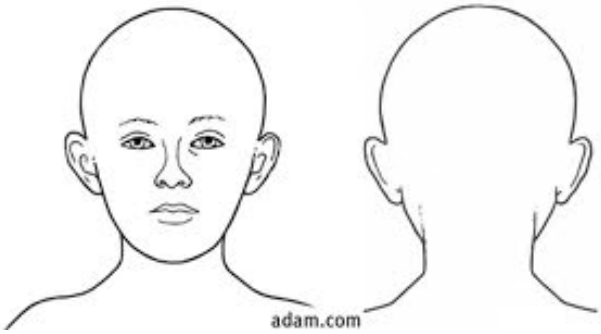


NASAL
1. Sinus Pain
2. Post Nasal Drainage
3. Allergic Conditions

EYE
1. Red Eyes R L
2. Light Sensitive R L
3. Pain Behind Eyes R L
4. Tears in Eyes R L

MOUTH
1. Abnormal Opening
2. Bad Bite
3. Missing Jaw Teeth
4. Excessive Mouth Breathing
5. Grind/Clench on Teeth

NECK & SHOULDERS
1. Pain R L
2. Stiffness R L
3. Poor Posture ____
4. Swallowing Difficulties ____



How long has the area(s) been a problem for you? _____
_____
_____

Have you had a head injury, head trauma (concussion or whiplash)? _____ When? _____
Prior surgeries: _____
Medications: _____
Allergies: _____ Latex allergy: YES NO

Do you have any digestive concerns? _____
_____
Do you have a history of emotional / physical trauma or sexual abuse? _____ When? _____
Do you wear a retainer or other dental appliance? _____ For approximately how many hours a day? ___

(Continue on back of page if necessary)