

Arkansas Dental Health  
&  
TMJ Therapy Center

TMJ HEALTH HISTORY

# **Sam L. Beavers, D.D.S.**

(800) 275-8651

E-mail: ADHABEAV@aol.com

---

- Diplomate - American Academy of Pain Management
- Fellow - American Orthodontic Society
- Former President Chief of Staff - Arkansas Dental and Health Associates
- Associate Professor - Capitol University of Integrative Medicine, Washington, D.C.
- Member - Political Relations Committee, American Academy of Head, Neck, and Facial Pain
- Membership - American Academy of Pain Management
- American Academy of Head, Neck, and Facial Pain
- Board of Directors - International Association of Orthodontics
- International Association of Gnathological Orthopedics
- American Association of Functional Orthodontics
- Institute of Myofunctional Therapy
- American Dental Association
- Pulaski County Dental Association
- Central District Dental Association
- Senior Instructor - International Association for Orthodontics

## **Presentations**

Arkansas Physical Therapy Association, Little Rock, AR; Arkansas Headache And Pain Center,; Little Rock, AR; Baptist Hospital; Grand Rounds, Little Rock, AR; Arkansas Chiropractic Association,; Little Rock, AR; Mid South Orthodontic Institute, Memphis, TN; Southwest Hospital Pain Center,; Little Rock, AR; Pinnacle Hospital Pain Center, Little Rock, AR; Capitol University of Integrative Medicine,; Washington, D.C.; University of Arkansas Medical Science Center Otolaryngology Department.

## **Education**

Little Rock Central High - 1963  
Baylor University - 1967  
University of Tennessee - 1971  
Tennessee Public Health, Internship Received - 1972  
Institute of Myofunctional Therapy, Internship - 1995  
Capitol University of Integrative Medicine - 1998

## PATIENT INFORMATION

Instructions: Please answer all questions as accurately and thoroughly as possible. The completeness of your answers directly affects the diagnostics decisions made on your behalf. Although some questions may not seem applicable to you, there is a specific reason behind each question asked. This information will remain confidential at all times.

We realize that it will take considerable time to fill out this form. We can assure you this information will be reviewed in detail before, during, and after your examination.

### PLEASE PRINT

#### GENERAL INFORMATION

Name: \_\_\_\_\_

Child, Parents Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Home Phone : \_\_\_\_\_ Work Phone : \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Single      Married      Divorced      Separated      Widowed

Occupation: \_\_\_\_\_

Employed by: \_\_\_\_\_

Employers Address: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_

Spouses Occupation: \_\_\_\_\_

Employed By: \_\_\_\_\_

Employers Address: \_\_\_\_\_

Your Social Security Number: \_\_\_\_\_

Patient is a Minor, who is legally responsible? \_\_\_\_\_

Nearest Relative: \_\_\_\_\_

Address: \_\_\_\_\_

Who Referred You To Our Office? \_\_\_\_\_

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

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you presently under care of this person? \_\_\_\_\_

**INSURANCE INFORMATION**

If you have medical insurance, please complete the following:

Name of Insurance Carrier: \_\_\_\_\_

Name of Group Medical Plan: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employee: \_\_\_\_\_ Employees SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_ Has the patient had previous care under this plan? \_\_\_\_\_

If so name the plan: \_\_\_\_\_

If you have Dental Insurance, please complete the following:

Name of Insurance Carrier: \_\_\_\_\_

Name of Group Dental Plan: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employee: \_\_\_\_\_ Employees SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_ Has the patient had previous care under this plan? \_\_\_\_\_

If so name the plan: \_\_\_\_\_

**DENTIST / PHYSICIAN INFORMATION**

Name of General Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Last Complete Dental Examination? \_\_\_\_\_

Family Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Additional Physicians \_\_\_\_\_ Specialty: \_\_\_\_\_

Date of Last Complete Medical Exam: \_\_\_\_\_

**HISTORY**

When did you first experience the problems for which you are seeking help? Date \_\_\_\_\_

What are your specific complaints? From what symptoms do you most desire relief?

List from most important to least important:

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

Please list any particular time of day or activities which these problems are worst.

---

---

---

Please list any particular time of day or activities which seem to bring relief from these symptoms.

---

---

---

Does any of your family have the same or similar problem?    yes    no    if yes please explain:

---

---

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

---

---

---

**PREVIOUS TREATMENT**

Please list all the Dentists, Physicians, Chiropractors, Physical Therapists, Pain Center, or other therapists who have been involved in diagnosing or treating you for this condition. Please list in chronological order if possible. Include the individual's name, specialty, address, and phone number. Please list any success or failures that you experienced with each. If additional space is needed continue on last page.

---

---

---

---

---

---

---

---

---

---

**MEDICAL HISTORY**

Height \_\_\_\_\_ Weight \_\_\_\_\_

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

Yes No Have you ever had rheumatic fever? When? \_\_\_\_\_

Yes No Do you have high or low blood pressure? Is it controlled? \_\_\_\_\_

Yes No Have you had pains in the chest or shortness of breath? \_\_\_\_\_

Yes No Has your physician ever told you that you are anemic? \_\_\_\_\_

Yes No Have you ever had a stroke? When? \_\_\_\_\_

Yes No Have you ever had diabetes? How is it controlled? \_\_\_\_\_

Yes No Are you allergic to any medication? What? \_\_\_\_\_

Yes No Have you been advised not to take any medication? What? \_\_\_\_\_

Yes No Have you ever had tuberculosis? When? \_\_\_\_\_

Yes No Have you ever had Hepatitis? 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: \_\_\_\_\_

Yes No Is your diet medically supervised? For what purpose? \_\_\_\_\_

**MEDICAL HISTORY (Continued)**

For Women:

Yes No Are you pregnant? Expected delivery date? \_\_\_\_\_

Yes No Do you have a history of previous miscarriages? \_\_\_\_\_

Yes No Are you taking birth control pills? For how long? \_\_\_\_\_

Yes No Do you experience irregular menstrual cycles? \_\_\_\_\_

Yes No Have you had surgery on the female organs? (including tubal ligation)? \_\_\_\_\_

Yes No Have you reached menopause? If so, are you taking supportive medication? \_\_\_\_\_

Yes No Have you been told, or do you suspect, you may have Pre-Menstrual Syndrome? \_\_\_\_\_

**MEDICATION HISTORY**

Are you taking, or have you ever regularly taken, any of the following medications?

Please circle your answer

- NOW PAST NO Tranquilizers
- NOW PAST NO Barbiturates
- NOW PAST NO Sleeping Aids
- NOW PAST NO Thyroid
- NOW PAST NO Insulin
- NOW PAST NO Blood Pressure
- NOW PAST NO Heart
- NOW PAST NO Muscle Relaxants
  
- NOW PAST NO Nerve
- NOW PAST NO Pain
- NOW PAST NO Penicillin
- NOW PAST NO Tetracycline
- NOW PAST NO Stomach
- NOW PAST NO Birth Control
- NOW PAST NO Sinus/Allergy
- NOW PAST NO Cortisone/Steroids
- NOW PAST NO Aspirin

Please list the names of all drugs you presently take, strength (in milligrams), and how often you take each:

---



---



---

**FAMILY HISTORY**

Have your mother or father or their parents had any of the following disorders?

- Cancer       Alcoholism
- Diabetes       Dental Problems
- Arthritis       High Blood Pressure
- Allergies       Mental Problems
- Obesity       Heart Troubles
- Hemorrhoids       Arteriosclerosis
- Stroke       Kidney Disorders

**PERSONAL HISTORY**

Please list your most serious illness and injuries.

---



---



---

Please list injuries which you have had to include your head, jaw, or neck, including when you were a youngster:

---



---



---

Please list your operation history:

---



---



---

Please list any known allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any regular exercise you do:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate what position you usually sleep

in: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NUTRITIONAL HISTORY**

Please list any vitamins or minerals you regularly take.

Specify amount (number of milligrams a day)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How often do you have:**  
(Please answer with the following choices)

3 Times Daily      3 Times Week      3 Times Month      Never

- 1. Milk \_\_\_\_\_
- 2. Dairy Products \_\_\_\_\_
- 3. Coffee \_\_\_\_\_
- 4. Decaf Coffee \_\_\_\_\_
- 5. Refined Sugar \_\_\_\_\_
- 6. White Bread \_\_\_\_\_
- 7. Artificial Sugar \_\_\_\_\_
- 8. Soft Drinks \_\_\_\_\_
- 9. Pastries \_\_\_\_\_
- 10. Alcohol \_\_\_\_\_
- 11. Beer \_\_\_\_\_
- 12. Wine \_\_\_\_\_
- 13. Salt \_\_\_\_\_
- 14. Fresh Vegetables \_\_\_\_\_
- 15. Frozen Vegetables \_\_\_\_\_
- 16. Canned Vegetables \_\_\_\_\_
- 17. Salads \_\_\_\_\_
- 18. Fresh Fruits \_\_\_\_\_
- 19. Frozen Fruits \_\_\_\_\_
- 20. Canned Fruits \_\_\_\_\_
- 21. Red Meats \_\_\_\_\_
- 22. Fish \_\_\_\_\_
- 23. Seafood \_\_\_\_\_
- 24. Poultry \_\_\_\_\_
- 25. T.V. Dinners \_\_\_\_\_
- 26. Italian Food \_\_\_\_\_
- 27. Chinese Food \_\_\_\_\_
- 28. Fast Food \_\_\_\_\_
- 29. Tobacco \_\_\_\_\_
- 30. Fried Foods \_\_\_\_\_
- 31. Candy \_\_\_\_\_
- 32. Ice Cream \_\_\_\_\_
- 33. Tea (except herbal) \_\_\_\_\_

Do you usually eat:	YES	NO
Breakfast	___	___
Lunch	___	___
Dinner	___	___
Between Meals	___	___
Before Bed	___	___

**Symptom Survey**

Do any of the following activities cause you any pain or discomfort?

- Yawning       Brushing Teeth
- Chewing       Bending Neck
- Swallowing     Turning Head
- Speaking       Turning Trunk
- Singing       Moving Arms
- Shouting       Moving Shoulders

How often do you have pain? \_\_\_\_\_

If you have pain, please indicate the types you experience:

- Sharp       Throbbing
- Dull       Diffused
- Aching     Constant
- Deep       Intermittent
- Superficial     Cyclic

If you have pain, what is the intensity of your pain?

- Mild       Moderate       Severe

If you have pain, what is the longest period you have gone without pain? \_\_\_\_\_

If you have pain, what medications do you take to relieve it? \_\_\_\_\_

Did your symptoms start after any of the following?

- Injury to the jaw       "High" dental filling
- Injury to the neck     Dental treatment
- Injury to the head     Injury to the back
- Neck traction       Orthodontics (braces)
- Car accident       Head or neck surgery
- Yawning       General anesthetic
- Work-related injury     Whiplash injury
- Emotional upset       Broken jaw
- Excessive Mouth opening

Please circle the answer the following questions. If your answer to each question is "now" or "past," please fill in details where indicated. Also, please indicate whether the condition occurs on the right or the left.

NOW PAST NO Have you ever heard or felt popping, clicking, or cracking upon opening or closing your mouth?

\_\_\_ Right \_\_\_ Left

When did you first notice this? \_\_\_\_\_

Do you currently have this condition? \_\_\_\_\_

How frequently does it occur? \_\_\_\_\_

Do people around you notice this? \_\_\_\_\_

Do/Did any particular activities seem to cause it? \_\_\_\_\_

Is/Was there pain associated with this noise? \_\_\_\_\_

NOW PAST NO Has there ever been a time when your jaw "locked" closed or had a catch as you tried to open?

\_\_\_ Right \_\_\_ Left

Does your jaw presently feel like it is locked? \_\_\_\_\_

How many times has this occurred? \_\_\_\_\_

When was the last time it occurred? \_\_\_\_\_

NOW PAST NO Has your jaw ever locked open?

\_\_\_ Right \_\_\_ Left

How many times has this occurred? \_\_\_\_\_

Do any particular activities seem to cause it? \_\_\_\_\_

NOW PAST NO Do you have to move your jaw from side to side to open your mouth? \_\_\_\_\_

NOW PAST NO Do you have difficulty opening your mouth wide?

\_\_\_ Right \_\_\_ Left

How long have you had this problem?

NOW PAST NO Is there discomfort when opening your mouth?  
 Right  Left  
 How would you describe it?  
 Mild  Moderate  Severe

NOW PAST NO Do you have difficulty holding your mouth open for long periods? \_\_\_\_\_

NOW PAST NO Does your jaw swing to one side when you open or close your mouth?  
 Right  Left

NOW PAST NO Do / Did you have pain in your jaw?  
 Right  Left  
 When did you first notice this? \_\_\_\_\_  
 How long does/did it last? \_\_\_\_\_  
 What, if anything, relieves it? \_\_\_\_\_

NOW PAST NO Do you hear grating or gravel like sounds in your ears or jaw joints?  
 Right  Left  
 How frequently does this occur now? \_\_\_\_\_

NOW PAST NO Has the doctor told you have arthritis? \_\_\_\_\_  
 Which joints are affected? \_\_\_\_\_

NOW PAST NO Do you have "loose ligaments" in your joints, or been told you are "Double Jointed"? \_\_\_\_\_

NOW PAST NO Do you have frequent headaches (more then two per week)? \_\_\_\_\_  
 How often do they occur? \_\_\_\_\_  
 What part of the head are they located in? \_\_\_\_\_  
 What, if anything brings them on? \_\_\_\_\_  
 Are they usually accompanied by any of the following? \_\_\_\_\_  
 Neck aches  Jaw pain  Muscle tension  Emotional stress  
 Does medication relieve the pain?  Yes  No

- NOW PAST NO Do you frequently have neck aches or stiff neck muscles?  
 \_\_\_ Right \_\_\_ Left  
 How often? \_\_\_\_\_
- NOW PAST NO Do you frequently have pain in your shoulders or upper back?  
 \_\_\_ Right \_\_\_ Left  
 How often? \_\_\_\_\_
- NOW PAST NO Do you get low back pain? \_\_\_\_\_
- NOW PAST NO Does anything relieve this? \_\_\_\_\_
- NOW PAST NO Do you have problems with your ears? \_\_\_\_\_
- \_\_\_ Ringing or buzzing noises \_\_\_ Right \_\_\_ Left  
 \_\_\_ Congestion or Pressure or "stiffness" \_\_\_ Right \_\_\_ Left  
 \_\_\_ Pain \_\_\_ Right \_\_\_ Left  
 \_\_\_ Hearing loss \_\_\_ Right \_\_\_ Left  
 \_\_\_ Grating or cracking, or popping sounds \_\_\_ Right v Left
- NOW PAST NO Do you ever have periods of losing your balance or equilibrium?  
 Do you experience dizziness with this? \_\_\_\_\_  
 How often does this occur? \_\_\_\_\_
- NOW PAST NO Do you ever experience tingling or numbness in your hands or arms?  
 \_\_\_ Right \_\_\_ Left
- NOW PAST NO Do you ever experience pain radiating down your arms?  
 \_\_\_ Right \_\_\_ Left
- NOW PAST NO Do you awaken with awareness of your teeth or jaws?
- NOW PAST NO Do your jaw muscles frequently become tired, stiff or painful?  
 \_\_\_ Right \_\_\_ Left  
 \_\_\_ At the end of the day?  
 \_\_\_ After sleeping?  
 \_\_\_ During eating?

\_\_\_\_ Other Activities (Please specify)? \_\_\_\_\_

NOW PAST NO Does your face feel swollen? Where? \_\_\_\_\_

NOW PAST NO Do your jaw muscles ever feel excessively warm?

\_\_\_\_ Right \_\_\_\_ Left

NOW PAST NO Do your teeth hurt from biting pressure?

\_\_\_\_ Right \_\_\_\_ Left

NOW PAST NO Have you ever had an adjustment of your bite, or your teeth ground on to improve your bite?

When was this done? \_\_\_\_\_

How many times? \_\_\_\_\_

NOW PAST NO Have you ever had orthodontic treatment?

Did you have full braces? \_\_\_\_\_ For how long? \_\_\_\_\_

How old were you when you started treatment? \_\_\_\_\_

Did you have teeth removed as part of treatment? \_\_\_\_\_

Did you wear headgear during treatment? \_\_\_\_\_

Did you wear a retainer? \_\_\_\_\_ For how long? \_\_\_\_\_

What was your orthodontist's name? \_\_\_\_\_

NOW PAST NO Do you ever feel your jaw is over closed ( your jaw closes too far)? \_\_\_\_\_

NOW PAST NO Does your bite feel uncomfortable to you? How? \_\_\_\_\_

\_\_\_\_\_

NOW PAST NO Are there times when you cannot get your back teeth together? \_\_\_\_\_

NOW PAST NO Do you experience any of the following?

\_\_\_\_ Resting your tongue between your teeth?

\_\_\_\_ Biting your tongue?

\_\_\_\_ Biting your cheek?

\_\_\_\_ Biting your lip?

\_\_\_ Biting your nails?

\_\_\_ Biting other objects?

NOW PAST NO Are your teeth sensitive to any of the following?

\_\_\_ Cold drinks

\_\_\_ Hot drinks

\_\_\_ Sweets

\_\_\_ Biting pressure

NOW PAST NO Do your teeth feel loose or drifting?

NOW PAST NO Do you have spaces between your teeth where food catches?

NOW PAST NO Do you have more than three crowns (caps ) in your mouth?

NOW PAST NO Does your tongue usually rest on the floor of your mouth?

NOW PAST NO Does your tongue usually rest on the roof of your mouth?

NOW PAST NO Do you have difficulty getting food to go down properly when swallowing?

NOW PAST NO Does it take a lot of force to smile?

NOW PAST NO When you swallow, is your tongue on the roof of your mouth?

NOW PAST NO When you swallow, is your tongue on the floor of your mouth?

NOW PAST NO Do you have a burning sensation in your mouth?

NOW PAST NO Have you noticed any changes in your salivation?

NOW PAST NO Have you noticed any changes in the lubrication in your eyes?

NOW PAST NO Have your eyes tear frequently?

NOW PAST NO Do your eyes feel dry frequently?

NOW PAST NO Do you have pressure behind your eyes?

NOW PAST NO Do you have pain behind your eyes?

NOW PAST NO Do you get pain above your eyes?

NOW PAST NO Do you have a facial twitch?

NOW PAST NO Do you get sharp shooting pain in your face?  
Is this ever triggered by just touching the side of your face? \_\_\_\_\_

NOW PAST NO Do you ever feel you are under a significant amount of emotional stress or  
tension?  
How long have you had this? \_\_\_\_\_  
Do you think you deal / dealt with this stress in a healthy way? \_\_\_\_\_

NOW PAST NO Are there times when your symptoms are gone completely?  
  
How often? \_\_\_\_\_

Do these ailments disappear and then reoccur somewhat regularly, leaving you  
symptom-free for several days or even weeks at a time? \_\_\_ Yes \_\_\_ No

NOW PAST NO Do any of these ailments disrupt your life?  
In what way?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please mark your answer

Now Past No	Now Past No	Now Past No
___ ___ ___ Allergies	___ ___ ___ Varicose Veins	___ ___ ___ Painful Urination
___ ___ ___ Poor Digestion	___ ___ ___ Nervous Breakdown	___ ___ ___ Frequent Urination
___ ___ ___ Laxatives use	___ ___ ___ Alcoholism	___ ___ ___ Swollen Ankles

- \_\_\_ Stomach gas
- \_\_\_ Constipation
- \_\_\_ Ulcers
- \_\_\_ Diarrhea
- \_\_\_ Heartburn
- \_\_\_ Brittle fingernails
- \_\_\_ Fatigue easily
- \_\_\_ Low energy
- \_\_\_ Chronically tired
- \_\_\_ Depressed after work
- \_\_\_ 3 hrs. T.V. Daily
- \_\_\_ Frequent colds
- \_\_\_ Hands get cold
- \_\_\_ Feet Get Cold

- \_\_\_ Hyperactivity
- \_\_\_ Difficulty Sleeping
- \_\_\_ No Insomnia
- \_\_\_ Grind Teeth
- \_\_\_ Clenching Teeth
- \_\_\_ Muscle Spasms
- \_\_\_ Menstrual Cramps
- \_\_\_ Menopausal Problems
- \_\_\_ Shaking or Twitching
- \_\_\_ Muscle Tremors
- \_\_\_ Muscle Soreness
- \_\_\_ Osteoarthritis
- \_\_\_ Hand Tremors
- \_\_\_ Leg Cramps

- \_\_\_ Swollen Hands
- \_\_\_ Crave Salt
- \_\_\_ Scoliosis
- \_\_\_ Tonsillitis
- \_\_\_ Heart Troubles
- \_\_\_ Fast Pulse
- \_\_\_ Chest Pains
- \_\_\_ Heart Palpitations
- \_\_\_ Cardiogram
- When \_\_\_\_\_
- Results \_\_\_\_\_
- \_\_\_ Scarlet Fever
- \_\_\_ Lung Problems
- \_\_\_ Asthma

Please mark your answer

**Now Past No**

- \_\_\_ Arthritis Rheumatoid
- \_\_\_ On-Set Maturity
- \_\_\_ Brittle Diabetes
- \_\_\_ Irregular Menses
- \_\_\_ Slow Healing Sores
- \_\_\_ Poor Circulation
- \_\_\_ Hormone problems
- \_\_\_ Memory Loss
- \_\_\_ Sex Desire Reduced
- \_\_\_ Dizziness
- \_\_\_ I.U.D.

**Now Past No**

- \_\_\_ Joint Problems
- \_\_\_ Periodontal Disease
- \_\_\_ Nose Bleeds Often
- \_\_\_ Dental Infections
- \_\_\_ Dental Cavities
- \_\_\_ Sore Mouth
- \_\_\_ Metal Taste in Mouth
- \_\_\_ Denture Wearer
- \_\_\_ Had Oral Surgery
- \_\_\_ Cold Sores (Herpes)
- \_\_\_ Hearing Loss

**Now Past No**

- \_\_\_ Pneumonia
- \_\_\_ Chronic Cough
- \_\_\_ Sinus Problems
- \_\_\_ Drug Problems
- \_\_\_ Mononucleosis
- \_\_\_ Fainting Spells
- \_\_\_ Polio
- \_\_\_ Mental Retardation
- \_\_\_ Learning Disability
- \_\_\_ Schizophrenia
- \_\_\_ Psychological Care

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Vaginal Infections     | <input type="checkbox"/> Wear Glasses       | <input type="checkbox"/> Numb Fingers        |
| <input type="checkbox"/> Heavy Metal Problems   | <input type="checkbox"/> Gall Bladder       | <input type="checkbox"/> Excessive Hair Loss |
| <input type="checkbox"/> Essential Hypertension | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Colitis             |
| <input type="checkbox"/> Hypoglycemia           | <input type="checkbox"/> Lose Temper Easily | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Overweight             | <input type="checkbox"/> Perfectionist      | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Moody Often            | <input type="checkbox"/> Skin Rash          | <input type="checkbox"/> Cerebral Palsy      |
| <input type="checkbox"/> Emotional Upsets       | <input type="checkbox"/> Kidney Problems    | <input type="checkbox"/> Torticollis         |
| <input type="checkbox"/> Hemorrhoids            | <input type="checkbox"/> Blood Pressure     | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Drug Reactions         |   |  |

Please indicate anything else about yourself, which you suspect may be related to your condition:

---



---



---

I, the undersigned (patient or legally responsible party), authorize treatment to be rendered. It is understood that models, radiographs, records and photographs taken in the examination and treatment remain the property of the doctor.

Signature \_\_\_\_\_ Date \_\_\_\_\_

TBW/JLG  
 TMJ Management Systems

