Welcome to the REstore TMJ & Sleep Therapy, P.A.;

Thank you for considering our office for the diagnosis of your Headache, Facial Pain, Temporomandibular Joint Disorder or Sleep Breathing Disorder. Rest assured that you will have the latest in diagnostic procedures and the skill of a Texas licensed Dentist who is Board Certified both in Orofacial Pain and Dental Sleep Medicine. Our highly trained and certified team will answer any questions that you may have and assist you in an appropriate manner during the history and exam procedure as well as in your treatment.

Our ability to help you will depend on your thoroughness in filling out the assessment questionnaires you have in this packet. We ask that you take some time out of your busy schedule to fill them out completely, honestly and accurately. This will benefit you directly as it greatly enhances the accuracy of our diagnosis for your medical condition. Most Facial Pain or TMJ disorders are complex in nature and require a significant amount of time to understand. There are many interacting factors that influence the symptoms that you are having at this time.

We work very hard to keep our fees as low as possible. One way we accomplish this is by having our patients pay at the time services are rendered. We provide our patients several convenient options: cash, debit cards, check, Visa, MasterCard, American Express, Discover cards and interest free long-term payment plans. We also provide an insurance claim form at the time of each appointment in order to file with your insurance company.

As you fill in the following forms, please be sure to sign where indicated.

We look forward to meeting you for your scheduled consultation. If you have any questions or concerns, feel free to contact any member of our team. They will be delighted to assist you. Know that we have set aside a significant amount of time for you and would appreciate if there are any change in your plans, we be given at least 24 hour notice so we can help others waiting to get into our office for an assessment of their medical condition.

Sincerely,

Dr. Prehn, Dr. Phillips and Team
CONFIDENTIAL PATIENT INFORMATION  PLEASE PRINT ALL INFORMATION

Name____________________________________________________________________________________
First                Middle          Last
Nickname ____________________________
 Male   Female
Address__________________________________________Home telephone(      )__________________
City ________________ State_______ Zip________ Office telephone(      )__________________
Cell#__________________________________________Email Address_______________________________
Birth date ______________ Social Security ________________________Texas Drivers Lic.______________
Place of Employment (or school)____________________Address____________________________________

Physician___________________________Address________________________________________________
City_____________________ State__________Zip_____________Telephone(      )______________________
Dentist_____________________________Address________________________________________________
City______________________ State___________Zip____________Telephone(      )_____________________

Spouse name_______________________________________________________________________________
First     Middle     Last
Spouse Birth date_______________________Spouse Social Security #_______________________________
Spouse Drivers Lic._________________________Spouse Work #(       )_______________________________
Spouse Employment_________________________Address________________________________________

Responsible Party Information: Same as Patient check this box    OR if minor fill out the following:

Parent # 1
Name____________________________________________________________________________________
First                Middle          Last
Address________________________________________________________Home phone(      )__________________
City_____________________ State___________Zip______________Office phone(      )__________________
Birth date_______________________Social Security #_______________________________
Texas Drivers Lic._________________________Address________________________________________

Parent # 2
Name____________________________________________________________________________________
First                Middle          Last
Address__________________________________________Home phone(      )__________________
City_____________________ State___________Zip______________Office phone(      )__________________
Birth date_______________________Social Security #_______________________________
Texas Drivers Lic._________________________Address________________________________________

Whom may we thank for referring you to our office?____________________________________________
PLEASE HAVE YOUR INSURANCE CARD AVAILABLE TO MAKE A COPY
PLEASE SIGN AND DATE AT THE BOTTOM

- Please list the names of family members (i.e. spouse), attorney or other persons, if any, whom we may inform about your medical condition, diagnosis and financial responsibility.

- Please list the health care providers whom we may inform about your medical condition.
  Referring Doctor:______________________________________________________________
  Dentist:______________________________________________________________
  Physician:______________________________________________________________
  Other:______________________________________________________________

- What is the Pharmacy you would want any medications to be sent to for pick up?
  Pharmacy name: _____________________________________
  Pharmacy phone: (       ) __________________

Should further information be needed for my treatment with this office, I give consent to ask my respective health care provider or agency, to release any information to you.  ☐ YES  ☐ NO

I consent to the use of my medical record for the purpose of educating other healthcare providers. However, my identity will be kept confidential so that I will not be identified.  ☐ YES  ☐ NO

We will provide you with the necessary information to follow up with your insurance company.  Please read carefully:
(Your signature below means you agree)
- I understand that all charges incurred in this office are due at the time they are rendered.
- I understand that these fees may exceed the limit allowed by my insurance company.
- I understand that this office is not a provider for my insurance company, including Medicare, Medicaid, Workman’s Comp, Champus or TriCare.
- I understand that I will be responsible to file my claim to my insurance company.
- I authorize the release of medical records or other information needed for the insurance claim.
- I will be provided with fees prior to receiving treatment and I understand that I have the option to seek treatment from a participating provider.

The name and phone number of your nearest relative or close friend to notify in case of an emergency.

_____________________________________________ Date____________

Patient/Guarantor Signature:___________________________________ Date____________

Witness:___________________________________________________Date:____________
Sleep Questionnaire

Your Name: ____________________________  Age: ______  Date of Birth _________

Please check the following questions that apply to you:

☑  Do you snore?  ☐  Mild  ☐  Moderate  ☐  Severe?  How many years? ___
☑  Do you snore: ☐  On your side?  ☐  on your back?  Usual position:  ☐  back  ☐  side  ☐  stomach
☑  Do you fall asleep when reading, watching TV, or other passive activities?
☑  Do you fight sleepiness on the job or when driving?
☑  Do you most often wake with headaches?
☑  Do you ever wake choking or gasping for air?
☑  Do you most often wake up feeling tired, fatigued, and unrefreshed?
☑  Do you take naps during the day?  If so, for how long? ___
☑  Would you take a nap if you could?
☑  Do you have trouble falling asleep?  On average, how long to go to sleep? ______
☑  Do you have trouble staying asleep throughout the night?
   Number of times you wake up at night ___
   Length of time getting back to sleep after you wake up at night ___
☑  Do you have restless or “creepy, crawly” leg feelings?
☑  Do you experience unusual behaviors just before, during or after sleep?
☑  Do you ever wake up feeling paralyzed?
☑  Have you ever experienced a sudden loss of strength in your arms/legs during the day?
☑  Do you feel unhappy or discouraged about your sleep?
☑  Does your sleep problem affect your family life, work performance?
☑  How many caffeinated beverages do you have each day?   _____
☑  Do you think you get enough sleep at night?  Number of hours of sleep per night ____

Does your bed partner complain of:

☐  Your loud snoring?
☐  Your partner sometimes sleep in another room at night because of your snoring?
☐  Your twitching legs, kicking or excessive moving at night?
☐  Long breathing pauses during your sleep?

Do you have or ever had the following:

☐  Jaw popping, clicking or grinding?
☐  Your jaw ever locked or gotten stuck?
☐  Been diagnosed with TMJ?
☐  Been told you grind your teeth at night (brux)?
☐  Ever had a mouth guard made by a Dentist?
☐  Pain with chewing?
Rank how likely it would be for you to become drowsy during the day in the following situations:

0 = Would never doze  
1 = Slight chance of dozing  
2 = Moderate chance of dozing  
3 = High chance of dozing

Epworth Sleepiness Scale

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting &amp; Reading</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (i.e. theater)</td>
<td></td>
</tr>
<tr>
<td>As a car passenger for an hour without a break</td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after lunch without alcohol</td>
<td></td>
</tr>
<tr>
<td>In a car, stopped for a few minutes in traffic</td>
<td></td>
</tr>
</tbody>
</table>

Total score:

My sleep problems are:

Sleep Medications taken in the last year: (includes nonprescription)

☐ Do you have high blood pressure?
☐ Do you any heart problems?
☐ Do you have type 2 diabetes or any other blood sugar problems?
☐ Do you have acid reflux or wake with heartburn at night or in the morning?
☐ Do you feel as thorough as though you are over your healthy weight?

What is your Ht: _____ Wt: _____

Have you ever had a sleep study? ☐ Yes ☐ No

If YES, then please have the sleep lab fax results to: 281-296-6887. Thank you.
Patient Name:_________________________________________ Birth date:_________ Date: ___________

**Chief Concern (if pain, use level 0-10):** ______________________________________________

**Associated Symptoms and Pain Level (0-10):**

- Fullness in the ears/sinus
- Shoulder pain
- Tooth loss
- Episodes of locking closed
- Dizziness
- Change in hearing
- Upper backaches
- Bite is off
- Episodes of locking open
- Visual disturbances
- Ring/Buzz in ears
- Low backaches
- Tooth pain/sensitivity
- Jaw pain
- Insomnia/trouble sleeping
- Ear pain
- Eye pain
- Grinding
- Jaw locked closed now
- Stomach aches
- Facial pain
- Neckaches
- Clenching
- Pain while eating
- Fatigue
- Headaches
- Difficulty Swallowing
- Difficulty open/close mouth
- Other:
- Migraine
- Tongue pain
- Clicking of jaw
- Bruxism
- Neckaches
- Ear pain
- Jaw pain
- Broken teeth
- Grinding
- Broken teeth
- Grinding
- Morning headaches
- Electrical type pain
- Numbness
- Grinding
- Clenching
- Grinding
- Jaw pain
- Grinding
- Chewing
- Morning locked jaw  

Have you had a recent motor vehicle accident, a workers comp accident or any trauma to the head?  □ Yes □ No

Current medications including over the counter, supplements and vitamins (if long list, put on separate sheet):

---

**History of present illness:**

Quality: ______________________________________ (Example: dull ache, sharp, throbbing, pressure, etc.)  

Severity: ______________________________________ (How severe is the pain/problem on a scale of 1-10 with 10 the most severe?)  

Timing: ______________________________________ (Is the pain/problem intermittent, constant, AM, PM, etc.?)  

Duration: ______________________________________ (How long does the pain last?)  

Context: ______________________________________ (Where were you or what were you doing at the onset of this pain/problem? Eating, etc)  

Modifying factors: ______________________________________ (What makes the pain/problem worse or better? Chewing, opening jaw? Hot, cold? Talking?)  

Associated signs/symptoms: ____________________ (Any other symptoms not mentioned above?)  

Any prescription medications or Over the counter medications taken in the last year for this condition

---

**Patient social history:**

Marital status:  □ Single □ Married □ Separated □ Divorced □ Widowed  

Use of alcohol:  □ Never □ Rarely □ Previously, but quit: □ Daily, how much? □ Current packs / day: □  

Use of tobacco:  □ Never □ Rarely □ Type/Frequency: □  

Use of drugs:  □ Never □ Daily □ Type/Frequency: □  

Exercise how often? □ Never □ Rarely □ Moderate □ Daily

Type of exercise: ____________________________________________

Do you consider yourself a religious/spiritual person? □ yes □ no  

Do you have thoughts of suicide? □ yes □ no
**Review of Systems:** Please mark all that apply past or present (many of these concerns may have a direct effect on your problem)

- **CONSTITUTIONAL SYMPTOMS**
  - Good general health
  - Lately
  - Recent weight change
  - Fever
  - Fatigue

- **EYES**
  - Eye disease or injury
  - Wear Glasses/contact lenses
  - Blurred or double vision

- **EARS/NOSE/MOUTH/THROAT**
  - Hearing loss
  - Ear ringing
  - Ear aches or drainage
  - Chronic sinus problem
  - Nose bleeds
  - Mouth sores
  - Bleeding.
  - Bad breath or bad taste
  - Sore throat
  - Voice change
  - Swollen glands in neck

- **CARDIOVASCULAR**
  - Heart trouble
  - Chest pain or angina
  - Heart palpitation
  - Heart murmur
  - Swelling:
    - feet/ankles/hands

- **RESPIRATORY**
  - Chronic or frequent coughs
  - Spitting up blood
  - Shortness of breath
  - Wheezing

- **GASTROINTESTINAL**
  - Loss of appetite
  - Change in bowel movements
  - Nausea or vomiting
  - Frequent diarrhea
  - Painful bowel movements
  - Constipation
  - Rectal bleeding/ blood in stool
  - Abdominal pain

- **GENITOURINARY**
  - Frequent urination
  - Burning or painful urination
  - Blood in urine
  - Incontinence or dribbling
  - Kidney stones
  - Male - testicle pain
  - Female - pain with periods
  - Female - irregular periods
  - Female - vaginal discharge
  - Female - # of pregnancies
  - Other medical conditions not mentioned above?

- **NEUROLOGICAL**
  - Frequent or recurring headaches
  - Light headed or dizzy
  - Convulsions or seizures
  - Numbness or tingling sensations
  - Headache
  - Head injury

- **PSYCHIATRIC**
  - Memory loss or confusion
  - Anxious
  - Depression
  - Insomnia
  - Environmental allergies:

- **MUSCULOSKELETAL (NOT TMJ)**
  - Joint pain
  - Joint stiffness or swelling
  - Weakness of muscles or joints
  - Muscle pain or cramps
  - Back pain

- **INTEGUMENTARY (SKIN, BREAST)**
  - Rash or itching
  - Change in skin color
  - Change in hair or nails
  - Varicose veins
  - Breast pain
  - Breast lump

- **ENDOCRINE**
  - Glandal or hormone problem
  - Excessive thirst
  - Excessive urination
  - Heat or cold intolerance
  - Skin becoming dryer

- **HEMATOLOGIC/LYMPHATIC**
  - Slow to heal after cuts
  - Bleeding or bruising tendency
  - Anemia
  - Phlebitis
  - Past transfusion
  - Enlarged glands

- **ALLERGIC/IMMUNOLOGIC**
  - History of skin reaction or other adverse reaction to:
    - Penicillin or other antibiotics
    - Morphine, Demerol, or other narcotics
    - Novocain or other anesthetics
    - Antiflammatories
    - Tetanus antitoxin
    - Iodine, Merthiolate or other serums
    - Latex
    - Other drugs/medications:
    - Known food allergies:

---

**Previous Hospitalizations/Surgeries for Head and Neck**

<table>
<thead>
<tr>
<th>When?</th>
<th>Hospital, City, State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**Past Medical History** Have you ever had or have the following:

- Heart Attack
- Heart (Surgery, Disease)
- Chest Pain
- Congenital Heart Disease
- Heart Murmur
- High/Low Blood Pressure
- Mitral Valve Prolapse
- Artificial Heart Valve
- Heart Pacemaker
- Rheumatic Fever
- Arthritis/Rheumatism
- Cortisone Medicine
- Crohn’s disease
- Stroke
- Artificial Joints (knee, etc.)
- Kidney (renal) Disease
- Bladder Infections
- Ulcers
- Diabetes
- Thyroid Problems
- Glaucoma
- Emphysema
- Dizzy Spells
- Tuberculosis
- Asthma
- Latex Sensitivity
- Allergies or Hives
- Sinus Trouble
- Radiation Therapy
- Chemotherapy
- Tumors
- Cancer
- Drug Rehab/Detox
- Hepatitis A (Infectious)
- Hepatitis B (Serum)
- Venereal Disease
- A.I.D.S
- H.I.V. Positive
- Stomach problems
- Blood Transfusion
- Hemophilia
- Sickle Cell Disease
- Bruise Easily
- Liver Disease
- Diet
- (Special/Restricted)
- Neurological Disorders
- Epilepsy or Seizures
- Fainting Tendency
- Nervous/Anxious
- Psychological Care
- Migraine Headaches
- Fibromyalgia
Dental History:

Date of last dental visit: ___________ What was done? ________________________________
Do you have any dental problems now? ______________________________________________
What have been the character of your dental treatments in the past:
- Fillings
- Gum Disease
- Orthodontics, When?_______
- Broken Teeth
- Bite adjustment
- Oral Surgery, When?_______
Have you ever had your teeth ground or bite adjusted? Yes / No
Are any of your teeth sensitive to temperature or to chewing? Yes / No

Family Medical History:

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Diseases</th>
<th>If Deceased, Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Siblings</td>
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<td></td>
</tr>
<tr>
<td>Spouse</td>
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<td></td>
<td></td>
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<tr>
<td>Children</td>
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</tbody>
</table>

Is there anything else you would like us to know?

I understand the questions above and have answered them truthfully. I certify that I am the patient or legal agent for the patient.

Patient/Parent Signature: ____________________________________________ Date: _____________
Facial Pain Screening History

Name _______________________  Age ___ Date ______

Who have you seen (healthcare provider) for this condition?
_______________________________________________

If treatment was done, did any make you feel better?
_______________________________________________

Did any make you feel worse?
_______________________________________________

*On the figures below, please outline location of your pain:*

[Diagram of facial pain locations]

Mark intensity of pain in appropriate areas:
1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
(Little pain) (Worst pain imaginable)

TM Joint Dysfunction?
Does your jaw pop or click when you open? □ yes □ no
With pain? □ yes □ no
Which side pops/clicks? R / L
Which side has pain with popping? R / L
If your jaw has locked when did this first happen? ____________________________
Is the locking (circle one) Daily / Episodic
Does your jaw ever get “stuck”? □ yes □ no  When does this happen? ________________

If You Have Headaches?
“Normal Headaches”: Location: ___________ Intensity: ___ (1-10) How often? ___________
 □ Visual effects □ Light sensitivity □ Sound Sensitivity □ Dizziness □ Nausea □ Neck
What medications do you take for these headaches?
________________________________________

“Severe Headaches”: Location: ___________ Intensity: ___ (1-10) How Often? ___________
 □ Visual effects □ Light sensitivity □ Sound Sensitivity □ Dizziness □ Nausea □ Neck
 □ Severe headaches progress from the normal HA
 □ Severe headaches come out of nowhere
What medications do you take for these headaches? ___________________________

Does anyone in your family get migraines? □ Yes □ No  If yes, who? ___________________
Do you have any of the following:
YES  NO  Trouble going to sleep because of this condition?
YES  NO  Does your condition ever wake you?
YES  NO  Does this condition have a negative effect on the quality of your life?

Are you depressed?  □  Often  □  Sometimes  □  Never
Do you consider yourself?  □  Calm (laid back)  □  Moderate  □  Tense (uptight)
Do you have stress in your life?  □  None  □  Some  □  Enormous
Do you have thoughts of suicide?  □  None  □  Sometimes  □  Often

What percent of your pain relief do you expect with treatment? ________%
For you, is this condition (circle one)   long term / recent?
Do you sleep in the same room with someone who snores?  □ yes  □ no

If ‘yes’ does this disturb your sleep?  □ yes  □ no

What Does Your Pain Feel Like? Some of the words below describe your present pain. Circle only those words that describe it. Leave out any category that is not suitable.

1 Flickering  2 Jumping  3 Pricking  4 Sharp  5 Pinching
Quivering  Flashing  Boring  Cutting  Pressing
Pulsing  Shooting  Drilling  Lacerating  Gnawing
Throbbing  Stabbing  Lancinating  Cramping
Beating  Piercing  Stabbing  Crushing
Pounding  Lancinating  Dull

6 Tugging  7 Hot  8 Tingling  9 Dull  10 Tender
Pulling  Burning  Itchy  Sore  Taut
Wrenching  Scalding  Smarting  Aching  Squealing
Tugging  Searing  Stinging  Heavy  Splintering

1 Tiring  1 Sickenning  1 Fearful  1 Punishing  1 Wretched
1 Exhausting  2 Suffocating  3 Frightful  4 Grueling  4 Cutting

1 Annoying  1 Spreading  1 Cool  7 Nauseating
1 Troublesome  1 Tight  9 Nagging  7 Numb
Miserable  1 Radiating  1 Drawing  Gordon
Intense  1 Penetrating  1 Squeezing  Agonizing
Unbearable  1 Piercing  1 Tearing  Dreadful

Office use: Sensory ___  Affective ___  Evaluative ___  Total ___

I understand the questions above and have answered them truthfully. I certify that I am the patient or legal agent for the patient.
Patient/Parent Signature: ____________________________  Date: _____________