auroradentalcentre
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phone: 905.727.9220

Symptoms Screening Questionnaire:

Name:_____ Age:____ Sex:____Date:_____

DOB(M/D/Y):_____ Occupation:_____

What are you main concerns?

1.

2.

3.

Are you under the care of physician? ☐Yes ☐No
Why Not?

Are you aware if you have any neurological problems in your head/neck/body?
☐Yes ☐No
(please list)_____

Have you ever been treated for Stress Disorder? ☐Yes ☐No
Did you see a psychologist? ☐Yes ☐No

Are you aware if you suffer from any sleep disorders? ☐Yes ☐No
☐sleep seizures ☐insomnia ☐snoring ☐sleep apnea

Do you take any medications/vitamins/minerals? ☐Yes ☐No
Please list:

Do you have any allergies? ☐Yes ☐No
Please list:

Have you been hospitalized in the past year? ☐Yes ☐No
Why?

Have you had any surgeries in the past year?? ☐Yes ☐No
What?

Have you EVER sustained any head or neck trauma?? ☐Yes ☐No
What?

Do you believe you have a balanced diet and hydrate well? ☐Yes ☐No ***Please describe on the last page***.

Do you drink in excess of 2 cups of coffee/tea per day and/or do you drink a lot of soda pop and/or do you have a high sugar diet? ☐Yes ☐No
What?

Do you feel your occupation contributes to your pain or problem? ☐Yes ☐No
How?

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Do you have any of the following bad habits? (check please)

- ☐ Finger nail biting
- ☐ Carry heavy briefcase or handbag
- ☐ Chewing on ice
- ☐ Resting your head on your hands
- ☐ Sit in front of computer for a long time
- ☐ Pencil Chewer
- ☐ Thumb sucker
- ☐ Do you play a musical instrument

Please check any of the following symptoms you may have:

HEAD/FACE

- ☐ Forehead Pain
- ☐ Pain in your temples
- ☐ Tension/Migraine/Sinus headaches
- ☐ Pain in the back of your head
- ☐ Dizziness/Vertigo
- ☐ Balance Problems

Ear

- ☐ Ear Pain
- ☐ Decreased Hearing
- ☐ Clogged/Itchy/Stuffy ears
- ☐ Ringing/Buzzing in ears

THROAT

- ☐ Swallowing difficulties
- ☐ Feeling of Foreign object in throat
- ☐ Sore throat without infection
- ☐ Voice Changes
- ☐ Frequent Coughing or clearing

NASAL

- ☐ Sinus pain
- ☐ Sinus Problems
- ☐ Post nasal drainage
- ☐ Allergies

JAW

- ☐ Jaw Pain
- ☐ Jaw joint pain
- ☐ Clicking/popping jaw joint
- ☐ Grating Sound in Jaw
- ☐ Pain in cheek muscles
- ☐ Uncontrolled Jaw Movements
- ☐ Jaw Locks open/shut
- ☐ Jaw Deviates to one side opening/closing
- ☐ Difficulty Chewing
- ☐ Difficulty Kissing

EYES

- ☐ Pain/pressure behind eyes
- ☐ Blood shot eyes
- ☐ Eyes sensitive to light
- ☐ Constant/intermittent tearing of eyes
- ☐ Blurred vision

NECK

- ☐ Lack of Mobility/stiff neck
- ☐ Do you have neck pain
- ☐ Tired/Sore neck muscles
- ☐ Shoulder/Upper back pain
- ☐ Arm/finger-pain or numbness

MOUTH

- ☐ Do you have a limited opening
- ☐ Do you have trouble finding your bite
- ☐ Missing teeth
- ☐ Are you an excessive mouth breather
- ☐ Are you aware if you clench or grind your teeth-daytime or while you sleep
- ☐ When you open your mouth, does you mouth deviate to one side or the other
- ☐ Do you have general mouth muscle aches and pains

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Posture

- ☐Flat feet
- ☐Pain to sitting
- ☐Pain to stand
- ☐Rolled Shoulders
- ☐Scoliosis
- ☐Cross legs often while sitting
- ☐Low Back Pain
- ☐Drift when walking/bump into walls

Sleep

- ☐Difficulty waking in the morning
- ☐Snore
- ☐Frequent Awakening at night
- ☐Abnormal Morning Drowsiness
- ☐Sleep Apnea
- ☐Insomnia
- ☐Daytime Fatigue
- ☐Nighttime Gasping
- ☐Hours of sleep avg. _____
- ☐Have you ever had a sleep analysis done?
  - ☐Yes ☐No

X-Rays

Have you ever had an MRI/CT Scan/PET/PAN/CEPH/ taken? ☐Yes ☐No

Why?

What were the results?

Diet Analysis (from page 1):

In your own words, is there anything else that you would like to add pertinent to your situation (Genetics, other family members suffering, etc.)?: