TMJ & Sleep Apnea Center

Platinum Dental, Inc.

New Patient Questionnaire

Patient Name: _____ Date: _____

For us to better serve you on your upcoming visit, please fill out this short questionnaire. Thank you.

1. What is the main reason for your visit with our office?

2. Where is the location of your pain or discomfort?
   A. Cheeks B. Face C. head D. Jaw joints (Left / Right / Both)
   E. Jaw muscles F. Neck G. Shoulders H. Upper-back
   I. Others:_____

3. How long has this been bothering you?
   A. Days B. Weeks C. Months D. Years E. Others: _____

4. Has it been getting better, worse or staying the same?
   A. Better B. Worst C. Same D. Others:_____

5. What tends to make it worse? (such as eating, different foods or other things)

6. What tends to make it better? (Such as medication, activities, etc.)

7. What part of the day is your pain the worst?
   A. Morning B. Mid-day C. Night D. Others: _____

8. Have you seen any other health care provider for this problem?
   A. No B. Yes; (If yes, what type of health care provider?)
   A. Dentist B. Medical doctor C. Chiropractor D. Neurologist
   E. Others:_____