TMJ-Sleep Colorado, 1619 N. Greenwood Suite 308, Pueblo, CO 81003 719-544-0901

CHIEF COMPLAINT QUESTIONNAIRE

Name:_____ Date:_____
Age:_____ Date of birth:_____
Referred by:_____
Reason(s) for this appointment: ___Pain ___Sleep/airway ___Unknown

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU ARE SEEKING TREATMENT IN THIS OFFICE?
Please identify your chief complaint as #1, list all other symptoms in priority #2-9 for example)

		Recent	chronic (>6 months)			Recent	Chronic (>6 months)
_____	Headache pain	☐	☐	_____	Vision problems	☐	☐
_____	Ear Pain	☐	☐	_____	Kicking or jerking leg	☐	☐
_____	Jaw Pain	☐	☐	_____	Swelling in ankles or feet	☐	☐
_____	Pain when chewing	☐	☐	_____	Morning Hoarseness	☐	☐
_____	Facial Pain	☐	☐	_____	Dry mouth upon waking	☐	☐
_____	Eye Pain	☐	☐	_____	Fatigue	☐	☐
_____	Throat Pain	☐	☐	_____	Difficulty falling asleep	☐	☐
_____	Neck Pain	☐	☐	_____	Tossing and turning frequently	☐	☐
_____	Shoulder Pain	☐	☐	_____	Repeated awakening	☐	☐
_____	Back Pain	☐	☐	_____	Feeling unrefreshed in the a.m.	☐	☐
_____	Limited ability to open	☐	☐	_____	Significant daytime drowsiness	☐	☐
_____	Jaw joint locking	☐	☐	_____	Frequent heavy snoring	☐	☐
_____	Jaw joint noises	☐	☐	_____	Affects sleep of others	☐	☐
_____	Ear congestion	☐	☐	_____	Gasping when waking	☐	☐
_____	Sinus congestion	☐	☐	_____	Told that “I stop breathing” during sleep	☐	☐
_____	Dizziness	☐	☐				
_____	Tinnitus (ringing ears)	☐	☐	_____	Night-time choking spells	☐	☐
_____	Muscle twitching	☐	☐	_____	Unable to tolerate C-Pap	☐	☐
			☐	_____	Teeth grinding	☐	☐

_____ Other:_____

Do any of the above chief complaints affect your daily life and how?

_____

What are the results you are hoping to get from treatment?

Patient Signature:_____
Date_____