TMJ & Sleep Therapy Centre of San Diego

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Patient Information

Date: ____________

Patient Name: ______________________________ DOB: __________

Address: ____

Phone: ____________________ E-mail: ____________________

SCREENING FORM

For Patients with Head, Neck and Facial Pain & Sleep-Related Breathing Disorders/ Apnea

- ❑ Primary headaches or migraines
- ❑ Snoring/Sleep Apnea
- ❑ Disturbed, restless sleeping
- ❑ CPAP Intolerance
- ❑ Daytime drowsiness
- ❑ Attention deficit in children
- ❑ Earaches, stuffiness or ringing
- ❑ Neck, shoulder, back pain or stiffness
- ❑ Pain or soreness in TM joints
- ❑ Clicking or grating sounds in TM joints
- ❑ Limited mouth opening
- ❑ Locking jaw (opened or closed)
- ❑ Facial or undiagnosed teeth pain
- ❑ Other ____________________

Notes: ____

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Referring Physician

Name: ______________________________ Date: __________

Phone: ____________________ Fax: ____________________

❑ Exam ❑ 2nd Opinion ❑ Send Report ❑ Call me

Instructions

Email, Mail or Fax a copy to:

TMJ & Sleep Therapy Centre of San Diego

Scan for Web