Bluegrass Doctors of Physical Therapy, PLLC
The CranioFacial and TMJ Institute

Patient Contact Information

Today's Date_____

Patient Name_____

DOB_____

Address_____

City_____ State_____ Zip Code_____

Gender_____ Marital Status_____

Occupation_____

Home Phone_____ Cell Phone _____ Work Phone_____

Preferred number for contacting:

☐ Home ☐ Work ☐ Cell

Email_____

Employer_____

Work Phone _____

Work Address_____

City_____ State_____ Zip Code_____

Parent/Guardian/Spouse/Partner (Must complete if patient is under 18 years.)

Name_____

Address_____

City_____State_____ Zip Code_____

Home Phone_____ Cell Phone _____

Emergency Information/ Nearest Relative

☐ **Same as above**

Name_____Relationship_____

Address_____ City_____ State_____

Zip Code_____

Home Phone_____ Cell Phone _____

Work Phone _____

☐ Medical information can be shared with this person.

Physician Information

Name_____

Address_____ City_____ State_____

Zip Code_____

Phone Number_____

I/We authorize *Bluegrass Doctors of Physical Therapy, PLLC* to release all medical information and/or records to my requesting insurance company and/or referring physician (if referred from a physician).

_____ _____

Patient Signature Date

Patient Questionnaire

Name_____

From whom did you hear about us?_____

Are you currently pursuing or contemplating litigation for your condition for which you are seeking treatment (e.g. lawsuit, disability or workman's compensation). Yes_____ No_____ Not sure_____

History of current condition: (Please describe location, intensity, duration, and onset of condition. (Use back of form if needed.)

_____
_____
_____

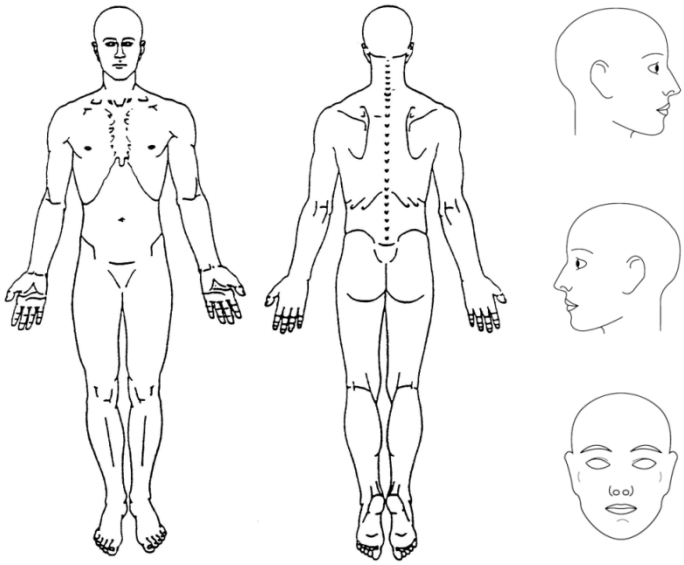
Any special tests that have been performed, the body part tested, and the results. (ie: X-ray, MRI, CT Scan)

_____
_____

Have you had any other treatments for your current condition? (ie: PT, Chiropractic, Massage, Acupuncture) Please list practitioners.

_____
_____

Please indicate the areas you are having pain.
You may shade, color or simply mark the areas.



Please rate the intensity of your pain at its worse below:
0-1-2-3-4-5-6-7-8-9-10
(no pain) (Worst Imaginable)

What has made your pain worse?

_____
_____
_____
_____

Please rate the intensity of your pain at its best below:
0-1-2-3-4-5-6-7-8-9-10
(no pain) (Worst Imaginable)

What has made your pain better?

_____
_____
_____
_____

Patient Questionnaire

Name_____

Have you been advised to have any surgery <u>that has not been done</u>? When and what?

_____

_____

Please list all previous injuries, accidents, surgeries and any other pertinent medical information.
(Please include dates and type of surgery.)

_____

_____

_____

_____

Please list ***all*** medical conditions and/or health concerns.

_____

_____

Please list ***all*** current medications.

_____

_____

_____

Please list ***all*** allergies including any latex, gels creams, adhesives or nickel allergies.

_____

_____

Do you currently have any metal, plastics or implants anywhere in your body?

_____

_____

Do you now have or have you had any of these symptoms in the past year? (Check all that apply)

- ☐ Change in bowel movements
- ☐ Persistent joint pain
- ☐ Irritable bowel
- ☐ Blood in bowel/urine
- ☐ Hot flashes
- ☐ Vertigo or dizziness
- ☐ Persistent nose bleeds
- ☐ Difficulty concentrating
- ☐ Learning disabilities
- ☐ Tiredness/fatigue
- ☐ Muscle spasms
- ☐ Fainting spells
- ☐ Eating disorder/difficulty eating
- ☐ Difficulty sleeping
- ☐ Seizures/Epilepsy
- ☐ Osteoporosis/Osteopenia
- ☐ Other_____

Patient Questionnaire

Name_____

Any history of: (check all that apply)

- ☐ None
- ☐ Kidney Problems
- ☐ Dislocations or loose joints
- ☐ Head or spinal injuries
- ☐ Recurrent headaches:
- ☐ How often _____
- ☐ Knocked unconscious:_____
- ☐ Meningitis
- ☐ Stomach ulcers
- ☐ Heartburn/indigestion
- ☐ Shortness of breath
- ☐ Anemia
- ☐ Asthma
- ☐ Bladder infection
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Depression
- ☐ Pelvic pain
- ☐ Smoking/Tobacco products: How much?_____
- ☐ Cancer? If so what kind?_____
- ☐ Other_____

DENTAL/FACIAL HISTORY: (Only for patients with headaches and TMJ)

Who is your dentist?_____

Please check all that apply:

- ☐ Braces: If so, When:_____
- ☐ Night splint/retainer
- ☐ Grind or clench teeth
- ☐ Recurrent sinus infections
- ☐ TMJ Pain/Dysfunction
- ☐ Popping or clicking in jaw
- ☐ Jaw locked
- ☐ Recurrent ear infections
- ☐ Pre-mature closure of cranial sutures

Please let your Bluegrass Doctor of Physical Therapy know if there is any other information that you feel is important for us to know.

_____

_____

_____

_____ _____

Patient Signature Date

_____

For office use: