REVIVE
OROFACIAL THERAPY AND WELLNESS CENTER

Patient Questionnaire

Patient Name:_____Date:_____

Please Mark an **X** next to the symptoms you are experiencing. Questions are for all ages.

Headache/Head pain:
___ Forehead ___ Temple ___ Back of head ___ Hair/scalp ___ Tender to touch ___ Sinus-type ___ Migraine-type

Eyes:
___ Pain in/behind eyes ___ Bloodshot eyes ___ Blurred vision ___ Visual disturbances

Mouth/Throat:
___ Teeth clenching ___ Grinding teeth ___ Tooth pain ___ Loose teeth ___ Teeth misaligned ___ Throat pain ___ Difficulty swalllowing ___ Mouth breathing

Ears:
___ Ear pain (no infection) ___ Ear congestion ___ Ringing/buzzing/hissing ___ Reduced hearing ___ Dizziness

Neck/Shoulders:
___ Neck pain ___ Shoulder pain ___ Back pain ___ Arm/finger pain ___ Arm/finger Numbness

Jaw/Face:
___ Jaw pain ___ Jaw locking/catching ___ Clicking jaw/jaw popping ___ Jaw joint noises ___ Limited mouth opening
___Inability to open smoothly ___ Pain when chewing ___ Jaw deviates to the side ___ Facial pain ___ Muscle spasm/cramps ___ Sinus congestion

Sleep:
___ Frequent snoring ___ Frequent heavy snoring, which affects the sleep of others
___ Significant daytime drowsiness ___ I have been told that "I stop breathing when sleeping"
___ Difficulty falling asleep ___ Gasping when waking up ___ Nighttime choking spells
___ Feeling unrefreshed in the morning ___ Morning hoarseness ___ Morning headaches
___ Swelling in ankles or feet ___ Nocturnal teeth grinding ___ Poor sleep ___ Feeling restless when lying down ___ Waking up frequently

Children:
___Hyperactivity ___Minimal or no spacing in baby teeth ___Thumb/Object sucking

****PLEASE REFER FOR CONSULTATION IF ANY OF THE ABOVE ARE MARKED. POSSIBILITY OF TMD AND/OR SLEEP DISORDERED BREATHING**