Childhood and Adult Orthodontics, Functional Facial Orthopedics, and TMJ Dysfunctions
14991E Hampden Ave, Suite #300, Aurora, Colorado 80014
Office: 303-690-0100, Email: info@aotmj.com

Patient Name: _____ **Date:** _____

Please identify which of the sysptoms below that you are experiencing by rating them based on the following scale:

4 = very severe 3 = severe 2 = moderate 1 = mild 0 = not experiencing

Headaches	_____
Facial Pain	_____
Neckaches	_____
Upper backaches	_____
Lower backaches	_____
Scoliosis	_____
Numbness in hands/fingers	_____
Subtotal	_____

Jaw joint pain	_____
Difficulty opening mouth	_____
Difficulty closing mouth	_____
Opening diviation of jaw to side	_____
Popping/clicking of jaw joint	_____
Grating of jaw joint	_____
Locking of jaw joint	_____
Subtotal	_____

Fullness in ears and sinuses	_____
Allergy problems	_____
Sinus problems	_____
Postnasal drainage	_____
Difficulty swallowing	_____
Chronic sore throat	_____
Asthma	_____
Subtotal	_____

Pain while eating	_____
Clenching/grinding of teeth	_____
Teeth sensitive to hot/cold	_____
Teeth sensitive when chewing	_____
Mouth breathing habit	_____
Subtotal	_____

Ear pain	_____
Hearing loss	_____
Ringing in ears	_____
Noise sensitivity	_____
Subtotal	_____

Eye pain	_____
Pain behind the eyes	_____
Visual disturbances	_____
Twitching of eyelids	_____
Light sensitivity	_____
Subtotal	_____

Nausea or upset stomach	_____
Dizziness/lightheadedness	_____
Loss of concentration	_____
Low self-esteem	_____
Fatigue	_____
Depression	_____
Forgetfulness	_____
Anxiety/panic attacks	_____
Loss of sleep	_____
Excessive dreaming/nightmares	_____
ADD/ADHD	_____
Subtotal	_____

Mitral valve prolapse	_____
Irregular heart beats	_____
Neorological disorders:	
Type:	_____
Other:	_____
Other:	_____
Subtotal	_____

Total _____

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Age: _____ Referral source: _____

Main objective: _____

Nasal Obstruction Symptom Evaluation

Please identify which of the sysptoms below that you are experiencing by rating them based on the following scale:

4 = very severe 3 = severe 2 = moderate 1 = mild 0 = not experiencing

Nasal congestion or stuffiness ..... _____
Trouble breathing through my nose ..... _____
Unable to breath through my nose during exercise or exertion ..... _____
Daytime mouth breathing ..... _____
Nightime mouth breathing ..... _____
Trouble sleeping ..... _____
Snoring ..... _____
Sleep Apnea (OSA) ..... _____

Total _____

Epworth Sleepiness Scale

Please identify which of the sysptoms below that you are experiencing by rating them based on the following scale:

3 = high chance of dozing 2 = moderate chance of dozing 1 = slight chance of dozing 0 = would never doze

Sitting and reading ..... _____
Watching TV ..... _____
Sitting inactive in a public place: theater, meeting, etc ..... _____
As a passenger in a car for an hour without a break ..... _____
Lying down to rest in the afternoon, when circumstances permit ..... _____
Sitting and talking to someone ..... _____
Sitting quietly after a lunch without alcohol ..... _____
In a car, while stopped for a few minutes in traffic ..... _____

Total _____

Daytime Sleepiness Index:

0-5 Average amount of daytime sleepiness, unlikely that abnormal sleep patterns are present
6-9 Mild to moderate daytime sleepiness, indicates possibility of abnormal sleep patterns
10-15 Excessive daytime sleepiness, may indicate need for medical treatment

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