GENERAL HISTORY

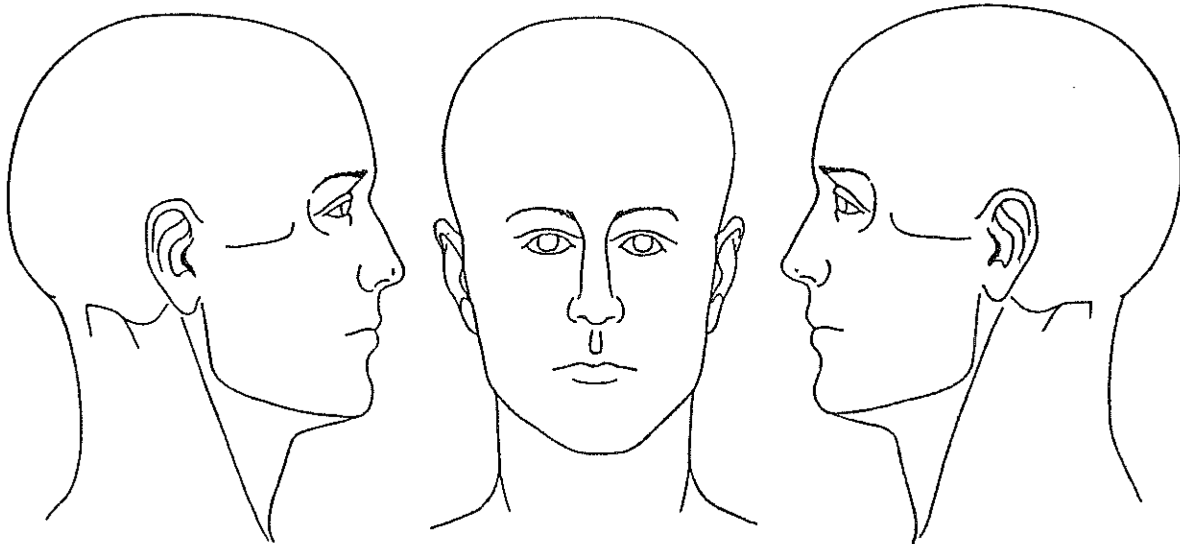
NAME ______________________ AGE __________ DATE ______________

CHIEF COMPLAINT ____

DATE OF INJURY ______________ OCCUPATION ______________________

REFERRING PHYSICIAN ____________________

FACE DIAGRAM: Please shade in the area of discomfort on the diagram below.



DISCOMFORT SEVERITY SCALE: 0 ________________________________ 10
(no pain) (worst pain)

HISTORY: Please check "yes" or "no"

HEART DISEASE	___	___
RESPIRATORY PROBLEMS	___	___
ALLERGIES	___	___
DIABETES	___	___
CANCER	___	___
OSTEOPOROSIS	___	___
CORTISONE	___	___

SPECIAL TESTS:

X-RAYS	___	___
LABORATORY	___	___
MYELOGRAM	___	___
ARTHROGRAM	___	___
OTHER TEST	___	___

APPROXIMATELY HOW LONG HAVE YOU HAD THIS PROBLEM ? ____________________________.

DOES YOUR JAW JOINT, GRATE _____; CLICK _____; POP _____; SNAP _____; OR LOCK _____.
WHICH SIDE ? RIGHT _____ LEFT _____ BOTH _____.

DO YOU HAVE HEADACHES ? YES ___ NO ___. HOW OFTEN ? DAILY ___; SEVERAL TIMES A WEEK ___.

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT ? YES/NO WHEN: ____________________________.

LIST RELATED SURGERIES & DATES: ____

____.

HAVE YOU EVER WORN BRACES ON YOUR TEETH ? YES ___ NO ___ WHEN: ____________________.

HAVE YOU EVER WORN A SPLINT IN YOUR MOUTH ? YES ___ NO ___ WHEN: __________________.
WHY: ____.

HAVE YOU HAD ANY SIMILAR PROBLEMS IN THE PAST ? IF SO, PLEASE EXPLAIN: _______________

____.

ARE YOU NOW ON ANY MEDICATION FOR THIS PROBLEM OR ANY OTHER PROBLEM ? ______________

____

PROBLEMS POSSIBLY PERTINENT TO PRESENT CONDITION: (Please Check)

	YES	NO
INJURY	___	___
VIRUS OR FLU JUST PRIOR	___	___
OVER TIRED JUST PRIOR	___	___
IMMOBILIZATION	___	___
UNUSUAL ACTIVITY	___	___

WHAT IS YOUR GENERAL LEVEL OF ACTIVITY ? (Please Circle)

Inactive   Mildly Active
Moderately Active   Very Active

HAS YOUR LEVEL OF ACTIVITY CHANGED ? ____.

IS YOUR GENERAL LEVEL OF STRESS OR ANXIETY: mild; moderate; severe

HAS YOUR LEVEL OF STRESS CHANGED ? ____.

WHEN DID THE PAIN BEGIN ? (date) ____.

WAS THE PAIN SUDDEN ___, GRADUAL ___, OTHER ____________________?

IS YOUR PROBLEM GETTING WORSE ___, BETTER ___, OR NOT CHANGING ___ ?

WHEN THE PROBLEM BEGAN, WAS YOUR DISCOMFORT IN EXACTLY THE SAME LOCATION AS YOU HAVE IT NOW ?

____

IS THE PAIN CONSTANT OR INTERMITTENT ? ____.

DOES YOUR PAIN BEGIN IN THE MORNING: AS THE DAY PROGRESSES; OR AT BEDTIME ? ___________.

WHAT AGGRAVATES YOUR PROBLEM ? ____.

WHAT RELIEVES YOUR PROBLEM ? ____.

DOES YOUR DISCOMFORT EVER AWAKE YOU AT NIGHT ? __________________________________.

IS IT HARD FOR YOU TO GET BACK TO SLEEP AFTER YOU ARE AWAKEN ? IF SO, HOW LONG ? ________

____

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

ANY SIGNIFICANT CHANGES IN WEIGHT LATELY ? ______________________

ANY CHANGES IN YOUR APPETITE LATELY ? ______________________

ANY CHANGES IN BOWEL OR BLADDER FUNCTION LATELY ? ______________________

ANY FEELING OF BEING OVERTIRED LATELY ? ______________________

ANY SHORTNESS OF BREATH ? ______________________

ANY GENERAL WEAKNESS, NAUSEA, DIZZINESS OR FEELING FAINT ? ______________________

SPECIFIC WEAKNESS OR LACK OF COORDINATION OR UNSTEADINESS ? ______________________

ANY DISCOMFORT ON EXERTION ? ______________________

ANY UNUSUAL DISCOLORATION OF SKIN ? ______________________

ANY SENSITIVITY TO COLD ? ______________________

IS THERE ANYTHING ELSE PERTINENT TO YOUR PROBLEM THAT WE HAVE NOT DISCUSSED ?

____

____

____

PATIENT'S GOALS: (1)

(2)

(3)

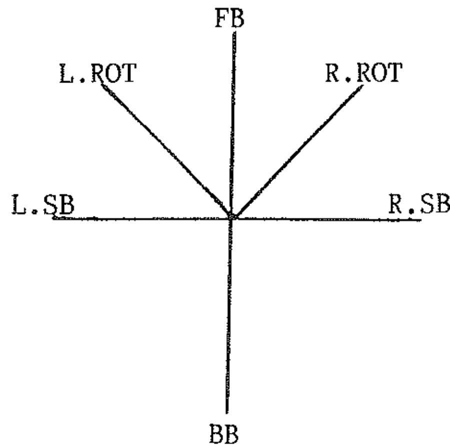
THERAPIST COMMENTS AND NOTES:

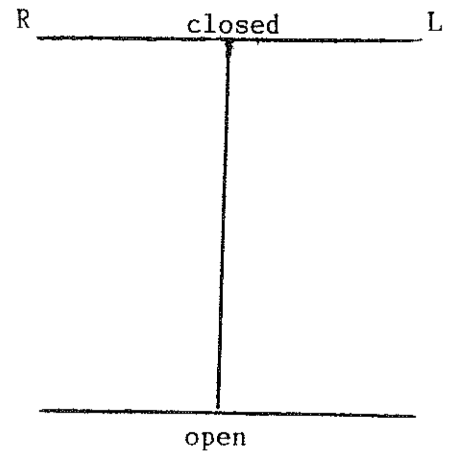
OBJECTIVE EVALUATION FORM (THERAPIST USE ONLY)

OBSERVATION & INSPECTION:

POSTURE:

ACTIVE RANGE OF MOTION:





PALPATION:

	LEFT	RIGHT
UPPER TRAPEZIUS		
BODY	____	____
OCCIPUT	____	____
LEVATOR SCAPULAE	____	____
SUBOCCIPITAL	____	____
TEMPORALIS	____	____
MASSETER	____	____
SCM	____	____
TEMPORALIS TENDON	____	____
LATERAL PTERYGOID	____	____

NEUROLOGY:

SENSATION ______________________________

REFLEXES ______________________________

STRENGTH (MMT) ______________________________

PROM: ______________________________

JOINT NOISES: ______________________________

ASSESSMENT: ______________________________

TREATMENT: ______________________________

GOALS: (1)
(2)
(3)
(4)

PLAN: ______________________________

____

EXERCISES: