# Comprehensive Health Questionnaire

**Demographic Information**

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

First Name:_______________Middle Initial:_____ Last Name:_______________

Age: _____ Date of Birth:_______________ Height: ________ Weight: ________

Ethnicity: ☐Native American/Alaska Native ☐Asian ☐African American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other ☐Decline to Answer

Responsible Party/Legal Guardian (if different than patient): _______________ Relationship: __________

**Contact Information**

Address:_______________ Address 2: _______________

City: _______________ State: _______________ Zip: _______________

Email: _______________ Home/Cell: _______________

Employer: _______________ Work Phone: _______________

**Referred by: _______________** ☐ Dentist ☐ Physician ☐ Patient ☐ Other

**Provider Information**

Dental Provider Office: _______________ Last Visit: ____________

**Dentist Name**: _______________ Office Phone: _______________

City: _______________ Sate: _____ Zip: ________

Primary Care Physician Office: _______________ Last Visit: ____________

**Doctor Name:** _______________ Office Phone: _______________

City: _______________ Sate: _____ Zip: ________

Additional Provider Office: _______________ Last Visit: ____________

Doctor Name: _______________ Office Phone: _______________

City: _______________ Sate: _____ Zip: ________

Patient/Parent Signature: _______________ Date: ______



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**Please answer below for: What is your chief concern and reason for this visit?**

_______________________________________________

_______________________________________________

**Do you currently experience any of the following symptoms?**

*Please number your top chief complaints 1-4*

*Recent is in the last 6 months, Chronic is longer than 6 months*

| | Recent | Chronic |
|---|---|---|
| _____ Back Pain | ☐ | ☐ |
| _____ Chewing Pain | ☐ | ☐ |
| _____ Ear Pain | ☐ | ☐ |
| _____ Eye Pain | ☐ | ☐ |
| _____ Facial Pain | ☐ | ☐ |
| _____ Headache (inside head) | ☐ | ☐ |
| _____ Headache (outside head) | ☐ | ☐ |
| _____ Jaw Pain | ☐ | ☐ |
| _____ Neck Pain | ☐ | ☐ |
| _____ Nerve Pain | ☐ | ☐ |
| _____ Shoulder Pain | ☐ | ☐ |
| _____ Tooth Pain | ☐ | ☐ |
| _____ Throat Pain | ☐ | ☐ |
| _____ Difficulty Closing Mouth | ☐ | ☐ |
| _____ Difficulty Opening Mouth | ☐ | ☐ |
| _____ Dizziness | ☐ | ☐ |
| _____ Dyskinesia | ☐ | ☐ |
| _____ Ear Stuffiness (congestion) | ☐ | ☐ |
| _____ Ear Itching | ☐ | ☐ |
| _____ Jaw Locking Open | ☐ | ☐ |
| _____ Jaw Locking Closed | ☐ | ☐ |
| _____ Muscle Spasm | ☐ | ☐ |
| _____ Noises in Jaw Joints | ☐ | ☐ |
| _____ Numbness (Localized) | ☐ | ☐ |
| _____ Ringing in Ears (Tinnitus) | ☐ | ☐ |
| _____ Sinus Congestion | ☐ | ☐ |
| _____ Vision Problems | ☐ | ☐ |
| _____ Changes in Bite | ☐ | ☐ |
| _____ Dental Pain | ☐ | ☐ |
| _____ Teeth Crowding or Spacing issues | ☐ | ☐ |

| | Recent | Chronic |
|---|---|---|
| _____ Teeth Sensitivity | ☐ | ☐ |
| _____ Acid Indigestion | ☐ | ☐ |
| _____ Affect Sleep of Others | ☐ | ☐ |
| _____ Difficulty Falling Asleep | ☐ | ☐ |
| _____ Dry Mouth Upon Waking | ☐ | ☐ |
| _____ Fatigue | ☐ | ☐ |
| _____ Feeling Un-refreshed in the AM | ☐ | ☐ |
| _____ Frequent Heavy Snoring | ☐ | ☐ |
| _____ Morning Headaches | ☐ | ☐ |
| _____ Morning Hoarseness | ☐ | ☐ |
| _____ Night Sweats | ☐ | ☐ |
| _____ Nighttime Awakenings | ☐ | ☐ |
| _____ Nighttime Choking | ☐ | ☐ |
| _____ Nighttime Urination | ☐ | ☐ |
| _____ Shortness of Breath | ☐ | ☐ |
| _____ Significant Daytime Drowsiness | ☐ | ☐ |
| _____ Sore Jaw Upon Waking | ☐ | ☐ |
| _____ Swelling in Ankles or Feet | ☐ | ☐ |
| _____ Told I Stop Breathing at Sleep | ☐ | ☐ |
| _____ Teeth Grinding | ☐ | ☐ |
| _____ Teeth Clenching | ☐ | ☐ |
| _____ Tossing and Turning Frequently | ☐ | ☐ |
| _____ Unable to Tolerate C-Pap | ☐ | ☐ |
| _____ Vivid Dreams | ☐ | ☐ |
| _____ Jaw/Facial Fatigue upon waking | ☐ | ☐ |
| _____ Kicking or jerking of leg(s) | ☐ | ☐ |

_____ Any other symptoms not listed: _______________

_______________________________________________

**What is your level of head, neck or facial pain: 0 = no pain to 10 = worst possible pain**

**Currently: ______ At its best: ______ At its worst: ______**

**What are the results you are seeking from treatment?**

_______________________________________________

_______________________________________________

Patient/Parent Signature: ___________________________________________Date: ______



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**Sleep Conditions -** Please select the yes or no answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Position? ☐ Side ☐ Back ☐ Stomach ☐ Varies    Sleep Location? ☐ Bed ☐ Couch ☐ Chair ☐ Other

Bed Partner? ☐ Yes ☐ No    Average hours you sleep during the night? ______

**Is it easy to fall asleep?** ☐ **Yes** ☐ **No**    How many hours do you sleep during the day?______

**Do you wake often during the night?** ☐ **Yes** ☐ **No**    Cough, gasps or snorts on waking? ☐ Yes ☐ No

**Do you feel rested upon waking?** ☐ Yes ☐ No    Observed pauses in breath? ☐ Yes ☐ No

Stopped breathing during sleep? ☐ Yes ☐ No

Have you ever had a Sleep Study? ☐ Yes ☐ No ☐ HST ☐ PSG Date: ______ Result: ____________________

Previous Positive Airway Pressure Devices Used? ☐ CPAP ☐ BiPAP ☐ ASV ☐ APAP

Do you currently use a PAP Device? ☐ Yes ☐ No    Type: ______________________________________________

Have you previously used a Nighttime Oral Appliance? ☐ Yes ☐ No Type: ______________________________

**Allergic Reactions**

*Please check any and all medications or substance that have caused an allergic reaction*

☐ Anesthetics ☐ Antibiotics ☐ Aspirin

☐ Barbiturates ☐ Codeine ☐ Iodine

☐ Latex ☐ Metals ☐ Plastics

☐ Penicillin ☐ Sedatives ☐ Sulfa

☐ Food Allergies/Sensitivities ______________________________________________________________

Other: ______________________________________________________________________________________

**Current Medications**

***Please list all medications & supplements*** *(over-the-counter & prescription) you are taking and the reason you take them* ***OR Provide a copy of your personal Medication List***

| Medication | Dose | Reason for Taking |
|---|---|---|
| ______ | ______ | ______ |
| ______ | ______ | ______ |
| ______ | ______ | ______ |
| ______ | ______ | ______ |

☐ **See attached list**

**Previous Treatment, Medications and Other Therapies Attempted For The Condition We Are Evaluating**

| Treatment/Medication | Doctor/Provider | Approximate Date of Treatment |
|---|---|---|
| ______ | ______ | ______ |
| ______ | ______ | ______ |
| ______ | ______ | ______ |
| ______ | ______ | ______ |

☐ See attached

**Health And Medical History**

FOR FEMALE PATIENTS: Are you currently pregnant? ☐ Yes ☐ No

Do you drink 4 or more cups of coffee per day? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No

Do you consume alcohol or take sedatives for pain relief or sleeping aid? ☐ Yes ☐ No

Do you have trouble breathing through your nose? ☐ Yes ☐ No

Have you had prior orthodontic treatments? ☐ Yes ☐ No

Have you sustained injury to: ☐ Head ☐ Neck ☐ Face ☐ Teeth
☐ Other: ______ Approximate Date:______

**Surgical History -** *Have you had any of the following:*

General Anesthesia ☐ Yes ☐ No    Orthognathic Surgery ☐ Yes ☐ No

Adenoids Removed ☐ Yes ☐ No    Oral Surgery ☐ Yes ☐ No

Tonsils Removed ☐ Yes ☐ No    Removal of Third Molar(s) (Wisdom Teeth) ☐ Yes ☐ No

Jaw Joint Surgery ☐ Yes ☐ No

Other types of surgery:______________________________________________________________________

Patient/Parent Signature: ____________________________________________ Date: ______



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**Medical History – Patient and Family**

***Do you have or have experienced any of the following?***

| | PATIENT HX | FAMILY HX |
|---|---|---|
| AIDS/HIV | ☐ Yes ☐ No | |
| Anemia | ☐ Yes ☐ No | ☐ Fam Hx |
| Anxiety | ☐ Yes ☐ No | ☐ Fam Hx |
| Asthma | ☐ Yes ☐ No | ☐ Fam Hx |
| Awakenings from Sleep x | ☐ Yes ☐ No | ☐ Fam Hx |
| Bleeding Easily | ☐ Yes ☐ No | ☐ Fam Hx |
| Birth Defects | ☐ Yes ☐ No | ☐ Fam Hx |
| Bruising Easily | ☐ Yes ☐ No | ☐ Fam Hx |
| Cancer of ______ | ☐ Yes ☐ No | ☐ Fam Hx |
| Chemo | ☐ Yes ☐ No | ☐ Fam Hx |
| Chronic Fatigue | ☐ Yes ☐ No | ☐ Fam Hx |
| Cold Hands and Feet | ☐ Yes ☐ No | ☐ Fam Hx |
| **COPD** | ☐ Yes ☐ No | ☐ Fam Hx |
| **Depression** | ☐ Yes ☐ No | ☐ Fam Hx |
| **Diabetes** | ☐ Yes ☐ No | ☐ Fam Hx |
| Difficulty Concentrating | ☐ Yes ☐ No | ☐ Fam Hx |
| Difficulty Breathing at Night | ☐ Yes ☐ No | ☐ Fam Hx |
| Dizziness | ☐ Yes ☐ No | ☐ Fam Hx |
| Eating Disorder | ☐ Yes ☐ No | ☐ Fam Hx |
| (EDS) Ehlers-Danlos Syndrome | ☐ Yes ☐ No | ☐ Fam Hx |
| Emphysema | ☐ Yes ☐ No | ☐ Fam Hx |
| Epilepsy | ☐ Yes ☐ No | ☐ Fam Hx |
| Excessive Thirst | ☐ Yes ☐ No | ☐ Fam Hx |
| Fainting | ☐ Yes ☐ No | ☐ Fam Hx |
| Fibromyalgia | ☐ Yes ☐ No | ☐ Fam Hx |
| Fluid Retention | ☐ Yes ☐ No | ☐ Fam Hx |
| Frequent Colds/Flu | ☐ Yes ☐ No | ☐ Fam Hx |
| Frequent Cough | ☐ Yes ☐ No | ☐ Fam Hx |
| Frequent Ear Infections | ☐ Yes ☐ No | ☐ Fam Hx |
| Frequent Sore Throat | ☐ Yes ☐ No | ☐ Fam Hx |
| Gastroesophogeal Reflux | ☐ Yes ☐ No | ☐ Fam Hx |
| Glaucoma | ☐ Yes ☐ No | ☐ Fam Hx |
| Hay Fever | ☐ Yes ☐ No | ☐ Fam Hx |
| Hearing Impairment | ☐ Yes ☐ No | ☐ Fam Hx |
| Heart Attack | ☐ Yes ☐ No | ☐ Fam Hx |
| **Heart Disease** | ☐ Yes ☐ No | ☐ Fam Hx |
| Heart Murmur | ☐ Yes ☐ No | ☐ Fam Hx |
| Heart Pacemaker | ☐ Yes ☐ No | ☐ Fam Hx |
| Heart Palpitations | ☐ Yes ☐ No | ☐ Fam Hx |
| Heart Valve Replacement | ☐ Yes ☐ No | ☐ Fam Hx |
| Hemophilia | ☐ Yes ☐ No | ☐ Fam Hx |
| Hepatitis | ☐ Yes ☐ No | ☐ Fam Hx |
| **High Blood Pressure** | ☐ Yes ☐ No | ☐ Fam Hx |
| History of Substance Abuse | ☐ Yes ☐ No | ☐ Fam Hx |
| Huntington's Disease | ☐ Yes ☐ No | ☐ Fam Hx |

☐ **I HAVE NO FAMILY HX**

| | PATIENT HX | FAMILY HX |
|---|---|---|
| Hypoglycemia | ☐ Yes ☐ No | ☐ Fam Hx |
| **Insomnia** | ☐ Yes ☐ No | ☐ Fam Hx |
| Intestinal Disorder | ☐ Yes ☐ No | ☐ Fam Hx |
| Irregular Heartbeat | ☐ Yes ☐ No | ☐ Fam Hx |
| Kidney Disease | ☐ Yes ☐ No | ☐ Fam Hx |
| Leukemia | ☐ Yes ☐ No | ☐ Fam Hx |
| Liver Disease | ☐ Yes ☐ No | ☐ Fam Hx |
| Low Blood Pressure | ☐ Yes ☐ No | ☐ Fam Hx |
| Meniere's Disease | ☐ Yes ☐ No | ☐ Fam Hx |
| Memory Loss | ☐ Yes ☐ No | ☐ Fam Hx |
| Migraines | ☐ Yes ☐ No | ☐ Fam Hx |
| Mitral Valve Prolapse | ☐ Yes ☐ No | ☐ Fam Hx |
| Multiple Sclerosis | ☐ Yes ☐ No | ☐ Fam Hx |
| Muscle Aches | ☐ Yes ☐ No | ☐ Fam Hx |
| Muscle Fatigue | ☐ Yes ☐ No | ☐ Fam Hx |
| Muscle Spasms | ☐ Yes ☐ No | ☐ Fam Hx |
| Muscular Dystrophy | ☐ Yes ☐ No | ☐ Fam Hx |
| Neuralgia | ☐ Yes ☐ No | ☐ Fam Hx |
| Nervous system Disorder | ☐ Yes ☐ No | ☐ Fam Hx |
| Osteoarthritis | ☐ Yes ☐ No | ☐ Fam Hx |
| Osteoporosis | ☐ Yes ☐ No | ☐ Fam Hx |
| Ovarian Cyst | ☐ Yes ☐ No | ☐ Fam Hx |
| Parkinson's Disease | ☐ Yes ☐ No | ☐ Fam Hx |
| Poor Circulation | ☐ Yes ☐ No | ☐ Fam Hx |
| (POTS) Postural Orthostatic Tachycardia Syndrome | ☐ Yes ☐ No | ☐ Fam Hx |
| Psychiatric Care | ☐ Yes ☐ No | ☐ Fam Hx |
| Radiation | ☐ Yes ☐ No | ☐ Fam Hx |
| Recent Weight Gain | ☐ Yes ☐ No | ☐ Fam Hx |
| Recent Weight Loss | ☐ Yes ☐ No | ☐ Fam Hx |
| Rheumatic Fever | ☐ Yes ☐ No | ☐ Fam Hx |
| Rheumatoid Arthritis | ☐ Yes ☐ No | ☐ Fam Hx |
| Scarlet Fever | ☐ Yes ☐ No | ☐ Fam Hx |
| Shortness of Breath | ☐ Yes ☐ No | ☐ Fam Hx |
| Skin Disorder | ☐ Yes ☐ No | ☐ Fam Hx |
| Sinus Problems | ☐ Yes ☐ No | ☐ Fam Hx |
| Slow Healing Sores | ☐ Yes ☐ No | ☐ Fam Hx |
| Speech Difficulties | ☐ Yes ☐ No | ☐ Fam Hx |
| **Stroke** | ☐ Yes ☐ No | ☐ Fam Hx |
| Swollen or Painful Joints | ☐ Yes ☐ No | ☐ Fam Hx |
| **Thyroid Disease** | ☐ Yes ☐ No | ☐ Fam Hx |
| Tired Muscles | ☐ Yes ☐ No | ☐ Fam Hx |
| Tuberculosis | ☐ Yes ☐ No | ☐ Fam Hx |
| Urinary Tract Disorder | ☐ Yes ☐ No | ☐ Fam Hx |

OTHER ______________________________________________

Patient/Parent Signature: ______________________________________________ Date:______



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**Additional Symptoms – HEAD PAIN** **Please complete for all that apply:**

1. **Do you experience General Head Pain?** ☐Yes ☐No

| | Location (L = Left R = Right B = Bilateral) | Recent/Chronic (over 6mo.) | | Severity | | | Duration | | | Frequency | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Recent | Chronic | Mild | Mod | Severe | Hrs | Days | Wks | Occ. | Freq | Constant |
| 2. Temple Area | ☐L ☐R ☐B | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Back of Head | ☐L ☐R ☐B | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Forehead | ☐L ☐R ☐B | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Top of Head | ☐L ☐R ☐B | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**For the below categories, please indicate L or R where applicable**

**Jaw Pain** ☐ **I have no jaw pain**

Jaw pain with opening ☐L ☐R
Jaw pain when chewing ☐L ☐R
Jaw pain at rest ☐L ☐R

**Jaw Joint Sounds** ☐ **I have no jaw joint sounds**

Jaw sounds with opening ☐L ☐R
Jaw sounds when chewing ☐L ☐R

**Ear Related Conditions**

Buzzing in ears ☐L ☐R
Ear Congestion ☐L ☐R
Ear pain ☐L ☐R
Hearing Loss ☐L ☐R
Itchiness/stuffiness ☐L ☐R

Pain behind the ear ☐L ☐R
Pain in front of ear ☐L ☐R
Recurrent ear infections ☐L ☐R
Ringing in the ear (tinnitus) ☐L ☐R

**For the below categories, please respond with Yes or No .... *DO NOT LEAVE BLANK***

Jaw Locking

Jaw locks closed ☐Yes ☐No
Jaw locks open ☐Yes ☐No

Jaw Joint Symptoms

Teeth clenching ☐Yes ☐No ☐Day ☐Night
Teeth grinding ☐Yes ☐No ☐Day ☐Night

Eye Related Conditions

Blurred vision ☐Yes ☐No
Double vision ☐Yes ☐No
Eye pain ☐Yes ☐No

Pain or pressure behind the eyes ☐Yes ☐No
Extreme sensitivity to light ☐Yes ☐No
Wear of glasses or contacts ☐Yes ☐No

Throat Related Conditions

Chronic sore throat ☐Yes ☐No
Difficulty Swallowing ☐Yes ☐No
Swollen glands ☐Yes ☐No

Thyroid enlargement ☐Yes ☐No
Tightness in throat ☐Yes ☐No
Feeling of foreign object in throat ☐Yes ☐No

Neck related Conditions

Limited movement ☐Yes ☐No
Neck pain ☐Yes ☐No

Numbness in hands/fingers ☐Yes ☐No
Swelling in neck ☐Yes ☐No

Shoulder Conditions

Pain in Shoulders ☐Yes ☐No
Stiffness in Shoulders ☐Yes ☐No

Tingling in fingers/hands ☐Yes ☐No

Back Conditions

Low Back Pain ☐Yes ☐No
Middle Back Pain ☐Yes ☐No
Upper Back Pain ☐Yes ☐No

Scoliosis ☐Yes ☐No
Sciatica ☐Yes ☐No

Mouth/Nose Conditions

Chronic Sinusitis ☐Yes ☐No
Dry Mouth ☐Yes ☐No
Frequent Snoring ☐Yes ☐No

Broken Teeth ☐Yes ☐No
Biting Cheeks ☐Yes ☐No
Burning Tongue ☐Yes ☐No

Patient/Parent Signature: ______________________________ Date: ______



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**History of Symptoms**

On what date, or approximate date, did the condition you are seeking treatment for occur? ________________

Are any of the conditions listed or was your chief complaint caused by a motor vehicle accident? ☐Yes ☐No

If yes, what conditions: ______________________________________________ Date of accident: ______________

Does any family member have a sleep breathing disorder? ☐Yes ☐No If yes, explain: ____________________

_____________________________________________________________________________________________

## Please fully complete both sections 1. and 2. below

### 1. DAYTIME SLEEPINESS EVLAUATION - EPWORTH SLEEPINESS SCALE

For the following situations, answer with one of the following numbers:

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

| Situation | Score | Situation | Score |
|---|---|---|---|
| Sitting and reading | _____ | Sitting and talking to someone | _____ |
| Watching Television | _____ | Sitting quietly after a lunch (no alcohol) | _____ |
| Sitting, inactive public place | _____ | In a car, while stopped for a few minutes in traffic | _____ |
| As a passenger in a car for an hour without a break | _____ | Lying down to rest in the afternoon when circumstances permit | _____ |
| | | **TOTAL SCORE** | _____ |

### 2. NIGHTTIME SLEEPINESS EVALUATION

Developed by David White, M.D., Harvard Medical School, Boston, MA

1. Snoring — Score
   a) Do you snore on most nights (>3 nights per week)?
   Yes (2) No (0) _____
   b) Is your snoring loud? Can it be heard through a door or wall?
   Yes (2) No (0) _____

2. Has it ever been reported to you that you stop breathing or gasp during sleep?
   Never (0) Occasionally (3) Frequently (5) _____

3. What is your collar size?
   Male: Less than 17 inches (0) More than 17 inches (5)
   Female: Less than 16 inches (0) More than 16 inches (5) _____

4. Do you occasionally fall asleep during the day when:
   a) You are busy or active
   Yes (2) No (0) _____
   b) You are driving or stopped at a light?
   Yes (2) No (0) _____

5. Have you had or are you being treated for high blood pressure?
   Yes (2) No (0) _____

**TOTAL** _____

I

Patient/Parent Signature: ______________________________________________ Date: _____



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**3. PHQ-9 Patient Health Questionnaire**

1. *Over the **last 2 weeks,** how often have you been bothered by any of the following problems?*

| | Not at all | Several days | More than Half the days | Nearly every day |
|---|---|---|---|---|
| Little interest or pleasure in doing things | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling down, depressed, or hopeless | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Trouble falling/staying asleep, sleeping too much | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling tired or having little energy | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Poor appetite or overeating | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling bad about yourself or that you are a failure or have let yourself or your family down | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Trouble concentrating on things, such as reading the newspaper or watching TV | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Thoughts that you would be better off dead Or of hurting yourself in some way | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| COLUMN TOTALS | ______ + | ______ + | ______ + | ______ |
| TOTAL SCORE | ______ | | | |

2. *If you checked off any problem on the questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?*

☐ **not difficult at all** ☐ **somewhat difficult** ☐ **very difficult** ☐ **extremely difficult**



Patient/Parent Signature: ________________________________________ Date: ____________

**4. Generalized Anxiety Disorder (GAD-7) Questionnaire**

1. *Over the* ***last 2 weeks,*** *how often have you been bothered by any of the following problems?*

| | Not at all | Several days | More than Half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Not being able to stop or control worrying | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Worrying too much about different things | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling tired or having little energy | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Trouble relaxing | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Being so restless that it is hard to sit still | | | | |
| Becoming easily annoyed or irritable | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling afraid, as if something awful might happen | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| COLUMN TOTALS | ______ + | ______ + | ______ + | ______ |
| TOTAL SCORE | ______ | | | |

2. *If you checked off any problem on the questionnaire so far, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?*

☐ **not difficult at all** ☐ **somewhat difficult** ☐ **very difficult** ☐ **extremely difficult**

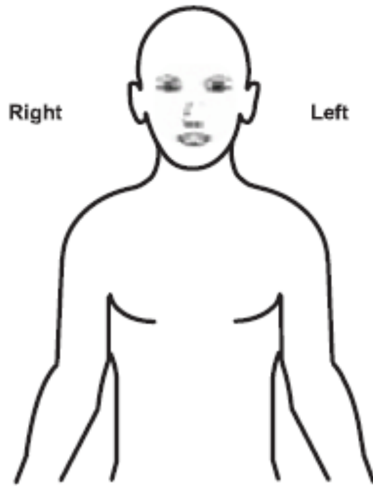
**Authorization to release**

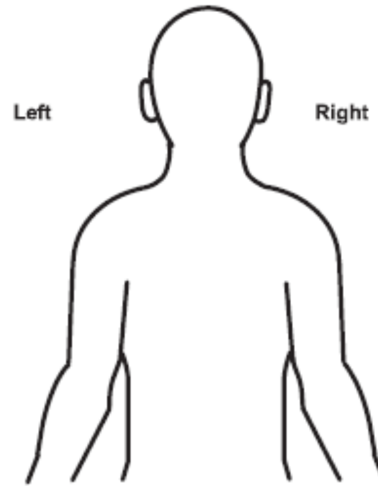
I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, third party billing companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient/Parent Signature:____________________________________________Date:________________



Patient/Parent Signature: ____________________________________________ Date: ____________



**Indicate Areas of Pain**
**Following the Pain Scale:**
**1 Mild pain**
**2 Moderate pain**
**3 Severe pain**



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