TMJ Clinic
Physiotherapy & Osteopathy

Last name:_____First name: _____

Mr__ Mrs__Ms__Miss__Dr__ Gender: Non-Binary: ____ Female: ____ Male: ____

Date of birth: (Month/Day/Year) _____

Home address: _____

City_____Postal code: _____

Telephone (home): _____ (Work): _____

(Cell):_____

E-mail (for online booking only): _____

Occupation: _____ Employer: _____

Reason(s) for consultation: _____

Date of beginning of symptoms: _____

Referred by: _____ Family Dr.: _____

Past surgeries (if any):_____

Medication: _____

Please circle if you have any of the following:

Cardiac problems or high/low blood pressure, metal implants, hypoglycemia, cancer, respiratory problems, IUD, dizziness, heart monitor, numbness, prosthesis, diabetes or other. (please specify):

Are you allergic to latex? : YES NO Any allergies? : YES NO _____

Please note: Compliance to physiotherapy and regular attendance results in a faster recovery and improves response to treatment. In order to respect other patients and physiotherapists, please cancel or change appointment 24 hours in advance. A fee of $50.00 may be applicable if this procedure is not followed.

Signature: _____ Date: _____

Name of Parent of Guardian, if under 18:_____

Daniel Gagné, Physiotherapist and clinic owner is the health information custodian (HIC) of this facility.

1335 Carling Ave. Suite 550 Ottawa, Ontario
Tel: 613.725.5000 Fax: 613.725.5001

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Permission to disclose information

I hereby authorize TMJ Physiotherapy Clinic and its therapists to disclose information obtained during my evaluation and treatment to my family doctor, dentist or other health professional managing my case (ex: initial report...)

Signature: _____ Date: _____

Permission to obtain information

I hereby authorize TMJ Physiotherapy Clinic and its therapists to obtain information considered essential and pertinent to the condition(s)for which I am evaluated, and or treated in physiotherapy (ex: x-ray results...) from my family doctor, dentist or other health professional managing my case.

Signature: _____ Date: _____

In the event that my claim to a third party payer or insurance company would not be allowed, I agree to pay any cost associated with the physiotherapy service and consultation, within a period judged reasonable.

Signature: _____ Date: _____

I fully understand the risk and benefits and agree to the treatment as explained. **(please initial following the assessment)**

Initials: _____

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A (Cranio-mandibular questionnaire) - circle the appropriate response

1. Pain located in the jaw

yes no

2. Muscle tension and/or trigger points of the jaw or neck muscles

yes no

3. Pain inside your mouth; pain when chewing; jaw fatigue

yes no

4. Pain: ringing in the ears, plugged ears: loss of hearing

yes no

5. Joint sounds, cracking of the jaw

yes no

6. Locking of the jaw (opened/closed)

yes no

7. Decreased amount of mouth opening or painful opening with deviation

yes no

8. Occlusion or bite problems

yes no

9. Orthodontic or dental work; change in facial features

yes no

10. Removal of teeth, including wisdom teeth

yes no

11. Trauma or past injury to the jaw

yes no

12. Snoring, unexplained difficulty sleeping

yes no

Signature:_____ Date: _____

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B (Cranial/cervical/headache questionnaire) – circle the appropriate response

1. Headaches (to temple, forehead, eyes, base of skull or other : _____		yes no
2. Type of headaches: sinus, tension, migraine, pulsating / constant:		yes no
3. Headache pain:	once per week	yes no
	1 to 3 times per week	yes no
	daily (intermittent/constant)	yes no
4. Intensity of pain:	minimal	yes no
	tolerable	yes no
	moderate	yes no
	severe	yes no
5. Response to analgesics:	pain abolished with medication	yes no
	pain diminished with medication	yes no
	no effect with medication	yes no
6. Dizziness, nausea		yes no
7. Visual difficulties; photophobia (intolerance to light)		yes no
8. Neck pain		yes no
9. Neck stiffness, difficulty turning head		yes no
10. Other areas of pain? Where? _____		yes no
11. Past head or neck injury		yes no
12. Nasal drip, dryness or pain		yes no

Signature:_____ Date: _____

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C (vertebral scan) – circle the appropriate response

Have you ever had:

	Past YES/NO	Present YES/NO
Lower back pain?	Y / N	Y / N
Pelvic area pain?	Y / N	Y / N
Pain in the buttock(s)?	Y / N	Y / N
Mid-back pain? Pain between the shoulder blades?	Y / N	Y / N
Rib pain?	Y / N	Y / N
Tingling, pins and needles or numbness?	Y / N	Y / N
Muscle weakness, loss of strength, muscle fatigue?	Y / N	Y / N
Rapid weight loss?	Y / N	Y / N
Unexplained fatigue?	Y / N	Y / N
Bowel or bladder (incontinence) problems?	Y / N	Y / N
Night pain?	Y / N	Y / N
Dizziness or balance problems?	Y / N	Y / N
A pregnancy?	Y / N	Y / N
Osteoporosis?	Y / N	Y / N
Long term use of cortico-steroids?	Y / N	Y / N
Spondylolisthesis, arthritis, diabetes?	Y / N	Y / N
Other:_____	Y / N	Y / N

Signature:_____ Date: _____

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