# 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: _____ State:_____ Zip: _____

Primary Care Physician Office: _____ Last Visit: _____

**Doctor Name:** _____ Office Phone: _____

City: _____ State:_____ Zip: _____

Additional Provider Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone:_____

City: _____ State:_____ Zip: _____

**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: _____

**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: _____

**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) | ☐Yes | ☐No |
| Jaw Joint Surgery | ☐Yes | ☐No | (Wisdom Teeth) | | |

Other types of surgery:_____

Patient/Parent Signature: _____ Date: _____

**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:_____

**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 (Mild Mod Severe) | Duration (Hrs Days Wks) | Frequency (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 | Pain behind the ear | ☐L | ☐R |
| Ear Congestion | ☐L | ☐R | Pain in front of ear | ☐L | ☐R |
| Ear pain | ☐L | ☐R | Recurrent ear infections | ☐L | ☐R |
| Hearing Loss | ☐L | ☐R | Ringing in the ear (tinnitus) | ☐L | ☐R |
| Itchiness/stuffiness | ☐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 | Pain or pressure behind the eyes | ☐Yes | ☐No |
| Double vision | ☐Yes | ☐No | Extreme sensitivity to light | ☐Yes | ☐No |
| Eye pain | ☐Yes | ☐No | Wear of glasses or contacts | ☐Yes | ☐No |

Throat Related Conditions

| | | | | | |
|---|---|---|---|---|---|
| Chronic sore throat | ☐Yes | ☐No | Thyroid enlargement | ☐Yes | ☐No |
| Difficulty Swallowing | ☐Yes | ☐No | Tightness in throat | ☐Yes | ☐No |
| Swollen glands | ☐Yes | ☐No | Feeling of foreign object in throat | ☐Yes | ☐No |

Neck related Conditions

| | | | | | |
|---|---|---|---|---|---|
| Limited movement | ☐Yes | ☐No | Numbness in hands/fingers | ☐Yes | ☐No |
| Neck pain | ☐Yes | ☐No | Swelling in neck | ☐Yes | ☐No |

Shoulder Conditions

| | | | | | |
|---|---|---|---|---|---|
| Pain in Shoulders | ☐Yes | ☐No | Tingling in fingers/hands | ☐Yes | ☐No |
| Stiffness in Shoulders | ☐Yes | ☐No | | | |

Back Conditions

| | | | | | |
|---|---|---|---|---|---|
| Low Back Pain | ☐Yes | ☐No | Scoliosis | ☐Yes | ☐No |
| Middle Back Pain | ☐Yes | ☐No | Sciatica | ☐Yes | ☐No |
| Upper Back Pain | ☐Yes | ☐No | | | |

Mouth/Nose Conditions

| | | | | | |
|---|---|---|---|---|---|
| Chronic Sinusitis | ☐Yes | ☐No | Broken Teeth | ☐Yes | ☐No |
| Dry Mouth | ☐Yes | ☐No | Biting Cheeks | ☐Yes | ☐No |
| Frequent Snoring | ☐Yes | ☐No | Burning Tongue | ☐Yes | ☐No |

Patient/Parent Signature: _____ Date: _____

**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** _____

Patient/Parent Signature: _____ Date: _____

**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 |
| Trouble relaxing | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Being so restless that it is hard to sit still | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Becoming easily annoyed or irritable | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling afraid, as if something awful might happen | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

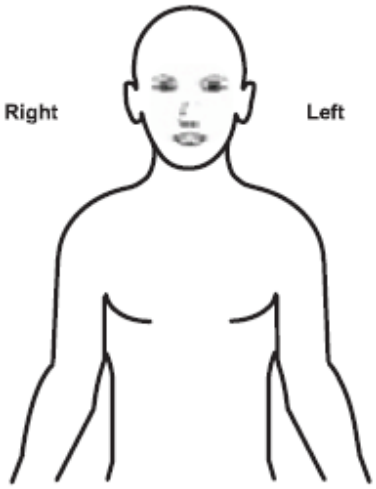
COLUMN TOTALS _____ + _____ + _____ + _____

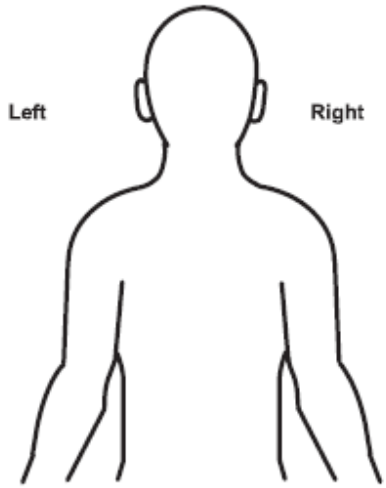
TOTAL SCORE _____

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**

Patient/Parent Signature: _____ Date: _____






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