Massage Ithaca

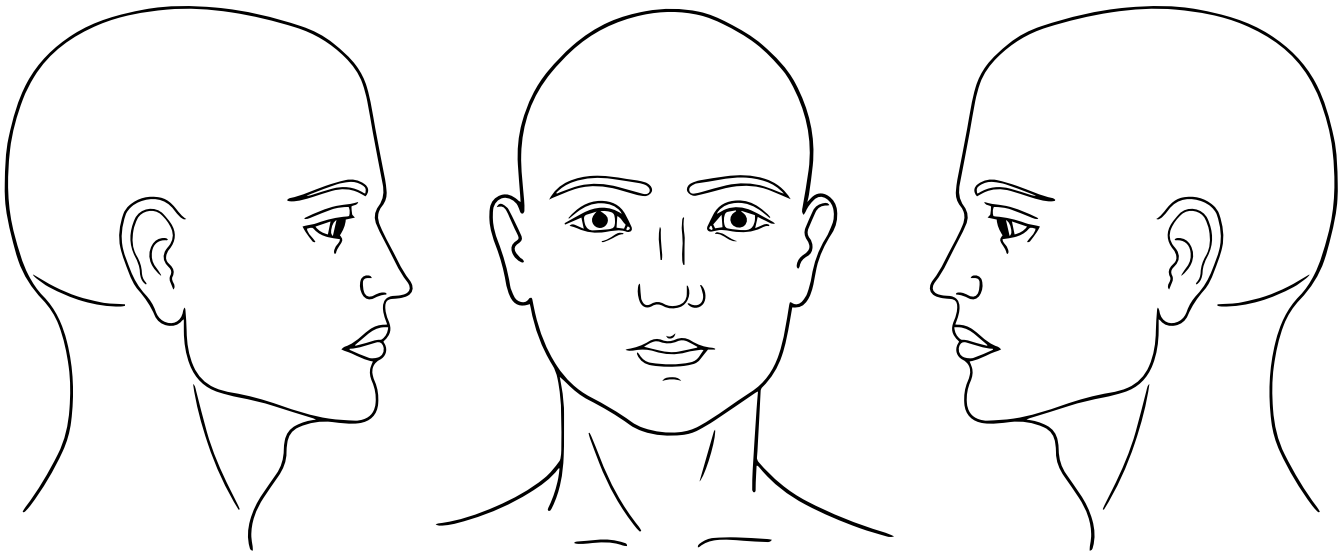
TMD CLIENT INTAKE FORM

Name_____ **Date of Birth** _____ **Sex** _____

Address_____ **City, State** _____ **Zip** _____

Phone_____ **Email** _____

On the diagram below, please shade, X, or circle the areas of pain and/or symptoms:



What symptoms are you experiencing in your JAW, HEAD, NECK?

Date when your symptoms first began: _____

What caused it? _____

Circle the number below to indicate your present level of JAW PAIN:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable) **Is the pain always present?** YES / NO

Circle the number below to indicate your present level of HEAD PAIN:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable) **Is the pain always present?** YES / NO

Circle the number below to indicate your present level of NECK PAIN:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable) **Is the pain always present?** YES / NO

How often do you have JAW PAIN? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How often do you have HEAD PAIN? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How often do you have NECK PAIN? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What makes it feel BETTER? _____

What makes it feel WORSE? _____

What treatments have you received? _____

What % of the day are your teeth touching? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Are you aware of oral habits such as:

- ☐ chewing your cheeks
- ☐ chewing objects
- ☐ biting your nails/cuticles
- ☐ taping your teeth together
- ☐ thrusting out your jaw
- ☐ moving tongue around
- ☐ not aware
- ☐ other _____

****Please mark any of the following conditions you may currently have.**

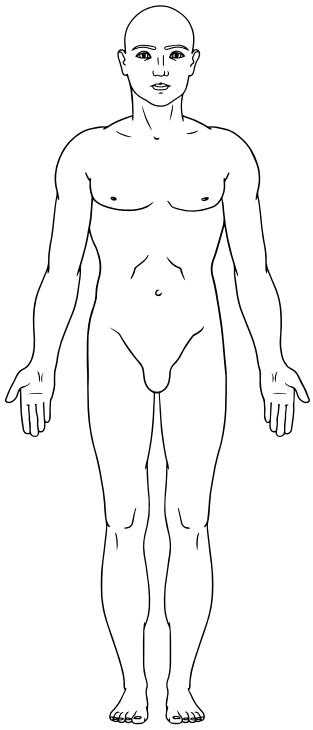
- ☐ Head/neck injury
- ☐ Sports injury
- ☐ Recent surgery
- ☐ Ear pain/stuffiness
- ☐ Sinus congestion
- ☐ Headaches
- ☐ Infection
- ☐ Tinnitus/ringing in the ears
- ☐ Vertigo/dizziness
- ☐ Disequilibrium/discoordination
- ☐ Mental confusion
- ☐ Chronic fatigue
- ☐ Irritability
- ☐ Anxiety
- ☐ Depression
- ☐ Eye Pain
- ☐ History of whiplash
- ☐ Trigeminal neuralgia/tic douloureux
- ☐ High blood pressure
- ☐ Bell's Palsy
- ☐ Sensory Processing Issues
- ☐ Allergies
- ☐ Tooth Pain
- ☐ Difficulty swallowing
- ☐ Decreased range of motion
- ☐ Others, please specify: _____

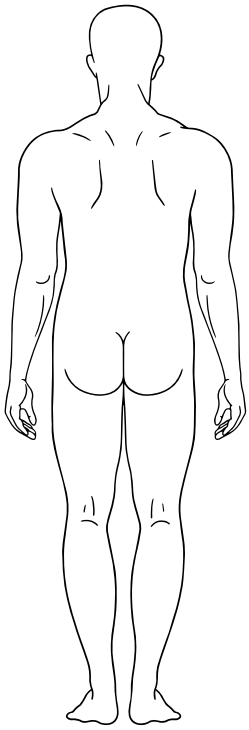
Please describe ANY ADDITIONAL present complaints, other than TMD :

Date when your symptoms first began: _____

What caused it? _____

On the body diagram below, please shade, X, or circle the areas of pain and/or symptoms where the additional problem(s) is/are:





Circle the number below to indicate your present level of PAIN:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable) **Is the pain always present?** YES / NO

What makes it feel BETTER? _____

What makes it feel WORSE? _____

Circle your job requirements: **Heavy Labor Light Labor Mainly Sitting Mainly Standing**

Can you perform your daily activities? **Yes, all activities. Only some. Not at all.**

Circle treatments have you received? **Surgery Medications Injections Acupuncture Exercise Physical Therapy Massage Therapy Chiropractic Adjustments**

I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm, or for in relief from pain and discomfort. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. I certify that the above information and the information on the past history form is complete and accurate to the best of my knowledge. I agree to notify my physician or therapists immediately whenever I have changes in my health condition in the future. I will inform the therapist of my current condition at the time of each visit.

Signature: _____ **Date:** _____

MINOR CONSENT:
I, _____ being the legal guardian of, _____authorize to seek, obtain and consent to treatment, as deemed necessary by Jennifer Whitaker, LMT.
Guardian's Address:
Phone Number:
Date of authorization:_____valid until revoked by me.