SCREENING FORM

For Patients with Head, Neck and Facial Pain & Sleep Disordered Breathing/Apnea

- ❑ Primary headaches or migraines
- ❑ Snoring/Sleep Apnea
- ❑ Disturbed, restless sleeping
- ❑ CPAP Intolerance
- ❑ Daytime drowsiness
- ❑ Attention deficit in children
- ❑ Earaches, stuffiness or ringing
- ❑ Neck, shoulder, back pain or stiffness
- ❑ Dizziness
- ❑ Pain or soreness in TM joints
- ❑ Clicking or grating sounds in TM joints
- ❑ Limited mouth opening
- ❑ Locking jaw (opened or closed)
- ❑ Facial or undiagnosed teeth pain
- ❑ Difficulty swallowing

When your patients experience one or more of these symptoms, they should have a thorough evaluation by a dentist trained in TM and Sleep. We will be happy to assist you in diagnosis and treatment for possible Craniomandibular, Temporomandibular or Sleep Disordered Breathing/Apnea.

Patient Information:

Name: _____

Address:_____

_____

Phone: _____

Referred by:

Name: _____

Signature: _____

Date: _____

☐ **Exam** ☐ **2nd Opinion** ☐ **Send Report** ☐ **Call Me**



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Instructions:

1. Mail or fax a copy to: **TMJ & Sleep Therapy Centre**
2. Give a copy to the patient
3. Keep a copy for your files