SYNERGY dental solutions
DENTISTRY DONE DIFFERENTLY

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Patient Name: _____ Date: _____

MEDICAL SCREENING & ASSESSMENT

DENTAL HARMONY

Yes ☐ No ☐ Do you have broken teeth or teeth missing because they were broken?

Yes ☐ No ☐ Do you or have you ever been diagnosed with gum disease (periodontitis)?

Yes ☐ No ☐ Are your teeth wearing down and/or getting shorter?

Yes ☐ No ☐ Does your bite feel uneven?

Yes ☐ No ☐ Have you had a history of or in need of extensive dental work?

Yes ☐ No ☐ Do you have crooked or crowded teeth?

Yes ☐ No ☐ Do you currently use any form of dental appliance therapy? If so, please describe: _____

Yes ☐ No ☐ Have you ever had trauma to your teeth or jaws? If so, please describe: _____

Yes ☐ No ☐ Have you always had problems with getting numb or having to return to the dentist for "high spots" and bite adjustments?

Yes ☐ No ☐ Have you had braces or other orthodontic therapy?

MUSCULAR BALANCE

Yes ☐ No ☐ Do you feel like your face and neck muscles are tired and sore most of the time?

Yes ☐ No ☐ Do you feel like you can't open your mouth wide enough to eat certain things?

Yes ☐ No ☐ Do you clench and grind your teeth when you are "stressed out"?

Yes ☐ No ☐ Do you have soreness in your neck?

Yes ☐ No ☐ Do you have persistent lower back tightness or pain?

Yes ☐ No ☐ Do you feel like you have to "fidget" to get comfortable?

Yes ☐ No ☐ Do you have pain or "knots" between your shoulder blades?

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MUSCULAR BALANCE (CONTINUED)

Yes ☐ No ☐ Do you feel that your ability to rotate or move your head is restricted by pain or discomfort?

Yes ☐ No ☐ Have you ever had a fall, car accident or whiplash? If so, when?

Yes ☐ No ☐ Do you get tension headaches?

JOINT STABILITY

Yes ☐ No ☐ Do your jaw joints grind, click or pop loud enough to routinely notice?

Yes ☐ No ☐ Do your jaws get stuck open or closed?

Yes ☐ No ☐ Do your jaw joints feel painful to touch when you open?

Yes ☐ No ☐ Do your jaw joints feel painful to touch when your mouth is closed?

Yes ☐ No ☐ Do you feel or hear the clicking and popping of your jaw joint when you place the pads of your pinky fingers in your ears with the pads facing forward?

Yes ☐ No ☐ Do you have congestion or ringing in your ears? *(tinnitus)*

Yes ☐ No ☐ Do you often feel like you have a “crick in your neck”?

Yes ☐ No ☐ Do you have numbness or tingling of your hands or fingers?

Yes ☐ No ☐ Do you have one leg that is longer than the other? ☐ Right ☐ Left

Yes ☐ No ☐ Do you have a “hunchback” appearance? *(prominent T1)*

NEUROLOGIC INTEGRITY

If you have headaches, please complete the Headache Assessment

Yes ☐ No ☐ Do you have dizziness or lightheadedness?

Yes ☐ No ☐ Do you have ringing in your ears or a feeling of fullness in your ears?

Yes ☐ No ☐ Do you have pain in or around your ears?

Yes ☐ No ☐ Do your eyes feel tired, uncomfortable, and painful or do you get headaches when reading or doing close work?

Yes ☐ No ☐ Do you get car sick or motion sickness?

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NEUROLOGIC INTEGRITY (CONTINUED)

Yes ☐ No ☐ Do you feel anxiety on a continual basis?

Yes ☐ No ☐ Are you intolerant to temperature extremes?

Yes ☐ No ☐ Do you have a tendency to faint following stressful events?

Yes ☐ No ☐ Do you have a mitral valve prolapse or cardiac arrhythmia?

Yes ☐ No ☐ Have you ever had a concussion or head trauma? If so, when?

_____

AIRWAY SUFFICIENCY

Yes ☐ No ☐ Do you snore or been told that you do on a consistent basis?

Yes ☐ No ☐ Have you been diagnosed with Obstructive sleep apnea (OSA)?

Yes ☐ No ☐ Do you feel excessively tired during the daytime, especially when driving?

Yes ☐ No ☐ Is your lower jaw set further back than your upper by more than 4mm (1/4 in)? *(overbite)*

Yes ☐ No ☐ When your teeth are closed, do your lower teeth become more than halfway covered by your upper teeth? *(deep bite)*

Yes ☐ No ☐ Are you aware that you clench or grind your teeth at night time?

Yes ☐ No ☐ Do you have headaches or sore facial muscles in the morning?

Yes ☐ No ☐ When you look at yourself in the mirror with your mouth open, are you unable to see the back of your throat?

Yes ☐ No ☐ Are you unable to breathe through your nose with your mouth closed for three minutes?

Yes ☐ No ☐ Do you have chronic nasal blockage and/or allergies?

COMPREHENSIVE WELLNESS

Yes ☐ No ☐ Do you have diabetes?

Yes ☐ No ☐ Do you have high blood pressure or heart disease?

Yes ☐ No ☐ Do you have or have you had cancer?

Yes ☐ No ☐ Do you have an autoimmune condition? *(Lupus, Fibromyalgia, Reynaud's, Rheumatoid arthritis, Sjogren's, Psoriasis)*

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COMPREHENSIVE WELLNESS (CONTINUED)

Yes ☐ No ☐ Do you have periodontal disease?

Yes ☐ No ☐ Do you have a respiratory disorder? *(asthma, emphysema, COPD)*

Yes ☐ No ☐ Do you have any other form of chronic illness? If so, what?

Yes ☐ No ☐ Are you currently being treated for anxiety or depression? If so, are you taking any medications? Please list: _____

On a scale from 1-10 , what do you feel the current status of your overall health is

0	1	2	3	4	5	6	7	8	9	10
Unhealthy										Healthy

On a scale from 1-10, what do you feel the current status of your digestive health is

0	1	2	3	4	5	6	7	8	9	10
Unhealthy										Healthy

_____ Salivary PH Results

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HEADACHE ASSESSMENT

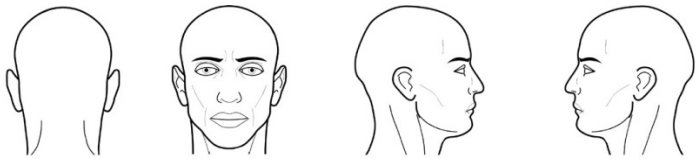
When did your current headache problem begin?

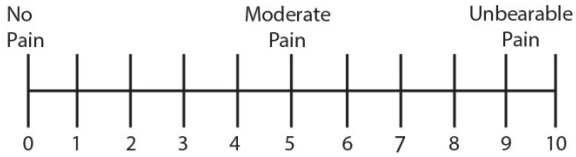
_____ ☐ months ☐ years

Have your headaches changed in the last six months?

☐ About the same ☐ Slight worsening ☐ Same but more frequent
☐ A lot worse ☐ New type of headache
☐ Got worse when _____

Where are your headaches located? *(Mark Locations)*





On a scale of 1-10, how painful are your headaches/migraines?

☐ Yes ☐ No Did you suffer from headaches when you were younger? If so,

☐ As a child ☐ In your 20s – 40s
☐ As a teenager ☐ In your 50s – 60s

When were your headaches at their worst?

_____

☐ Yes ☐ No Was there a specific event that caused your current headache problem?

☐ None/Unknown
☐ First period ☐ Pregnancy
☐ Birth Control Pills ☐ Hormone Replacement
☐ Specific event _____
☐ Injury _____
☐ Car accident _____
☐ Illness _____
☐ Other _____

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How often do you get severe headaches/migraines that make it difficult to function without treatment or medication?

☐ Occasionally ☐ More than once a month
☐ More than twice a year ☐ More than once a week

How often do you get other milder headaches?

☐ Daily ☐ More than 2 per month
☐ More than 3 per week ☐ Other _____

☐ Yes ☐ No Are your headaches increasing in frequency? If so, describe frequency

☐ Weekdays ☐ Spring ☐ Fall
☐ Weekends ☐ Summer ☐ Winter

Headaches typically begin,

☐ Gradually ☐ Suddenly ☐ Varies

Headaches usually being in the

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

How long before they reach their maximum intensity?

_____ ☐ minutes ☐ hours

How bad are your headaches?

With medication ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating
Without medication ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating

Headaches prevent activities such as

☐ School ☐ Work ☐ Household Chores ☐ Other _____

What does your headache pain typically feel like?

☐ Pressure ☐ Stabbing ☐ Throbbing ☐ Tight Band
☐ Burning ☐ Dull Ache ☐ Other

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Do any of the following bring on/trigger your headaches?

- ☐ Specific food triggers. If so, please see next question for specifics.
- ☐ Too much caffeine
- ☐ Not getting enough caffeine
- ☐ Fatigue
- ☐ Too little sleep
- ☐ Too much sleep *(sleeping in)*
- ☐ During stressful times
- ☐ After stress *(first day of vacation, weekend, after a test)*
- ☐ Menstruation
- ☐ Sexual Activity
- ☐ Coughing
- ☐ Weather changes
- ☐ Prolong computer work
- ☐ Certain odors
- ☐ Loud sounds
- ☐ Bright lights/sun
- ☐ Other _____

If you are aware of food triggers, please list your trigger foods below.

_____

How did you become aware of your triggers? *(Please check all that apply and provide detail if necessary)*

- ☐ Observation/instinct _____
- ☐ Trial and error _____
- ☐ By completing food/symptom diaries _____
- ☐ Suggestion from MD, dietician, naturopath _____
- ☐ Other _____

Do you experience any of the following before your headache begins?

- ☐ Mood changes
- ☐ Personality changes
- ☐ Change in appetite
- ☐ Food Cravings
- ☐ Neck Pain
- ☐ Fatigue
- ☐ Other _____
- ☐ No, I don't experience any of these

Do you experience any of these symptoms during your headaches?

- ☐ Nausea/upset stomach
- ☐ Vomiting
- ☐ Numbness or tingling
- ☐ Lightheadedness
- ☐ Dizziness
- ☐ Vertigo
- ☐ Difficulty concentrating
- ☐ Mood changes
- ☐ Irritability

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☐ Teary eyes ☐ Runny or stuffy nose
☐ Loud sounds bother you ☐ Strong smells/odors bother you
☐ Bright lights/sun bothers you
☐ Increased sensitivity of ☐ Scalp ☐ Hair ☐ Ears

What other doctors have you seen or tests have you had for your pain headaches, and/or migraines

☐ Family Doctor ☐ Oral/Maxillofacial Specialist
☐ Dentist (if other) ☐ Psychiatrist/Psychologist
☐ Physical Therapist ☐ MRI/CT Scan/Blood Work
☐ Chiropractor ☐ Other _____

What medications are you currently taking to alleviate your headaches?

_____

What medications or therapies have you previously tried to alleviate your headaches?

_____

☐ Yes ☐ No Do you try non-medicating techniques for managing your headaches?

☐ Breathing Exercises ☐ Yoga ☐ Cold Packs
☐ Physical Therapy ☐ Medication ☐ Massage
☐ Other _____

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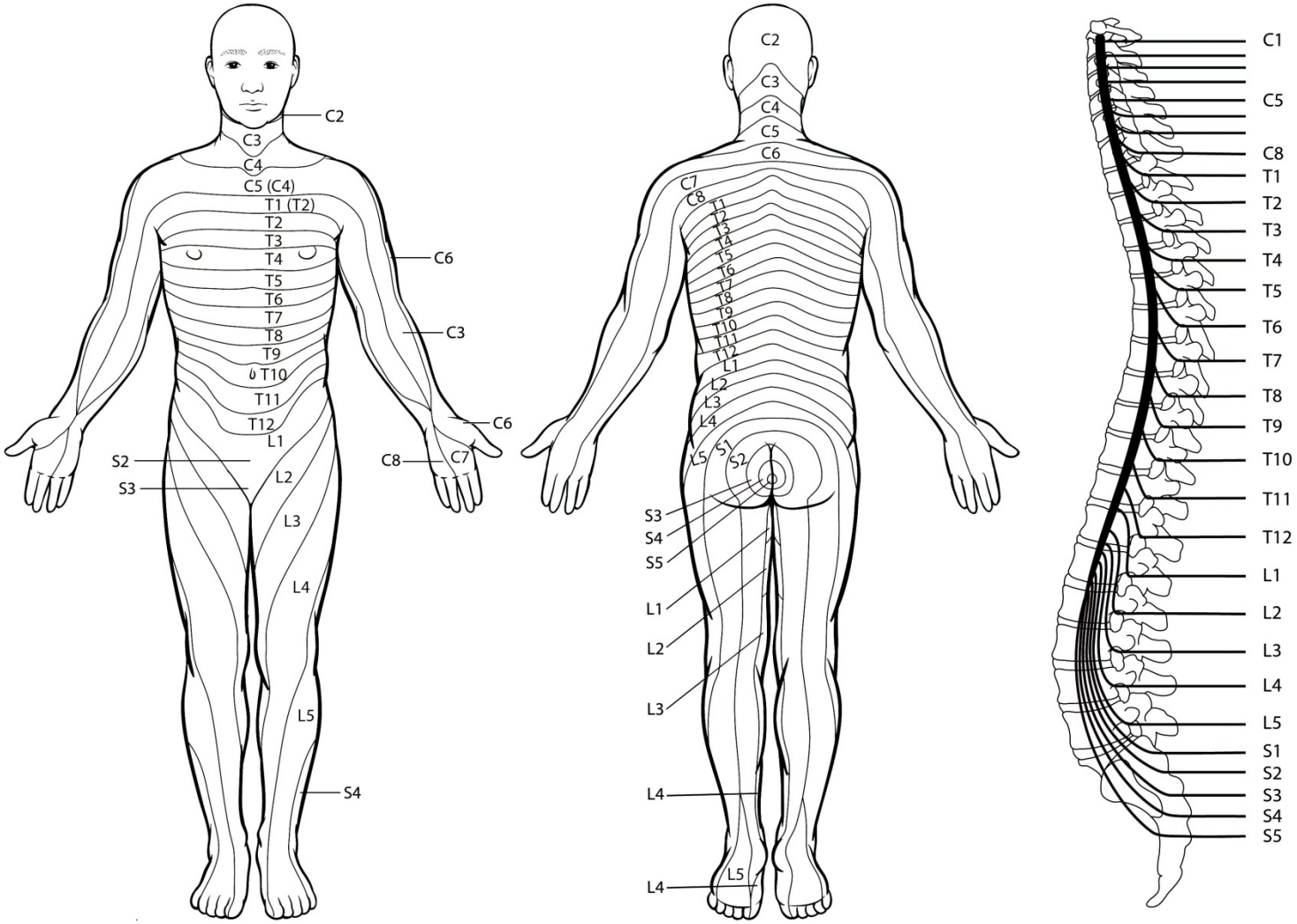
BODY PAIN ASSESSMENT FORM

Circle the area(s) you are experiencing discomfort.



Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name	Middle Initial	Last Name

Tally ARES Risk Points

Weight	Pounds	**Age**	Years	Gender: **Male** ◯ **Female** ◯
Height	Feet / Inches		**Neck Size**	Inches
Date of Birth	Month / Day / Year		**ID Number**	Optional

Neck Size
+2 Male ≥16.5
+2 Female≥15.0

Score ☐

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ◯	No ◯	Stroke	Yes ◯	No ◯
Heart disease	Yes ◯	No ◯	Depression	Yes ◯	No ◯
Diabetes	Yes ◯	No ◯	Sleep apnea	Yes ◯	No ◯
Lung disease	Yes ◯	No ◯	Nasal oxygen use	Yes ◯	No ◯
Insomnia	Yes ◯	No ◯	Restless leg syndrome	Yes ◯	No ◯
Narcolepsy	Yes ◯	No ◯	Morning Headaches	Yes ◯	No ◯
Sleeping Medication	Yes ◯	No ◯	Pain Medication e.g., vicodin, oxycontin	Yes ◯	No ◯

Co-morbidities +1 for each Yes response

Score ☐

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

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

	0	1	2	3
Sitting and reading	◯	◯	◯	◯
Watching TV	◯	◯	◯	◯
Sitting, inactive, in a public place (theater, meeting, etc)	◯	◯	◯	◯
As a passenger in a car for an hour without a break	◯	◯	◯	◯
Lying down to rest in the afternoon when circumstances permit	◯	◯	◯	◯
Sitting and talking to someone	◯	◯	◯	◯
Sitting quietly after lunch without alcohol	◯	◯	◯	◯
In a car, while stopped for a few minutes in traffic	◯	◯	◯	◯

Epworth Score **TOTAL** the values from all 8 questions,
If 11 or less **Score = 0**
If 12 or more **Score = 2**

Score ☐

Frequency **0 - 1 times/week** **1 - 2 times/week** **3 - 4 times/week** **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you wake up choking or gasping?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ◯ Rarely ◯ +1 Sometimes ◯ +2 Frequently ◯ +3 Almost always ◯ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ◯ Rarely ◯ Sometimes ◯ Frequently ◯ Almost always ◯

Assign points for each of the first three responses

☐
☐
☐

Signature	Area Code	Phone Number	**Total all 6 boxes from above**	**Point Total**
			If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	☐