Dental History

Name/address of dentist:

Do you…

- ☐ ...suffer with jaw pain / clicky jaw / lock jaw?
- ☐ ...grind your teeth?
- ☐ ...wear a dental appliance/dentures?

Have you…

- ☐ ...worn an orthodontic brace?
- ☐ ...had dental surgery?
- ☐ ...had any permanent teeth removed?

Reason for today's visit

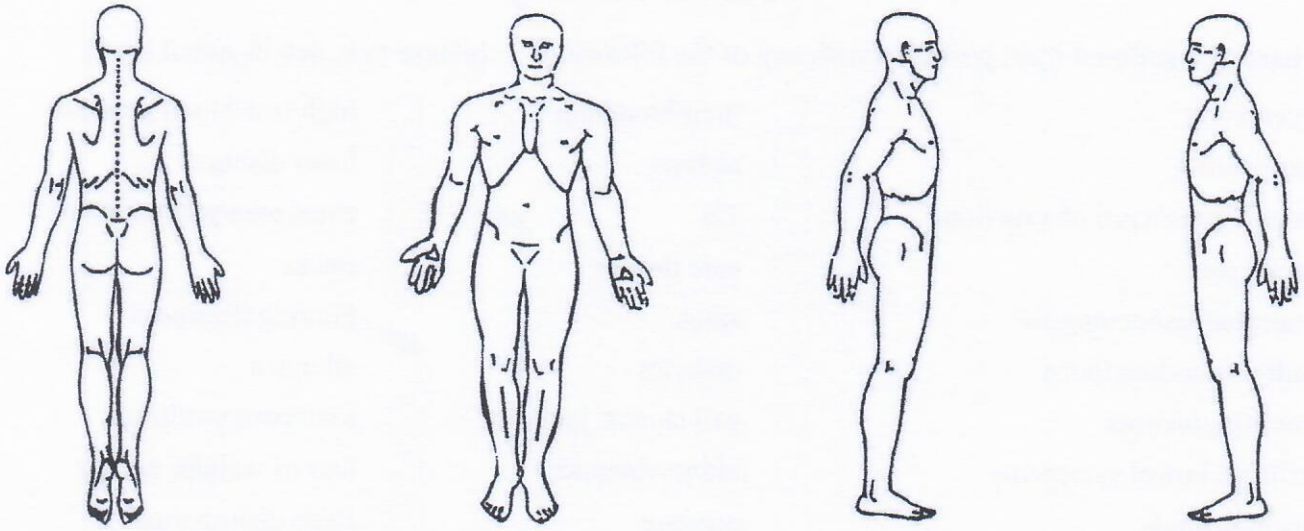
What symptoms, if any, do you have?

Any tests/diagnosis/treatment for present complaints?

If you are experiencing discomfort, where on a scale of 0-10 would you rate it? X at worst O at best

0 1 2 3 4 5 6 7 8 9 10

Please indicate where you have a complaint/s:



Have you received Chiropractic care before? Where and when?

Are you looking for:

Just pain relief? Pain relief and optimum corrective care? Maintaining your health after this episode?

Data protection

It is a requirement of data protection that we have written permission from you to allow us to communicate with other professionals involved in your health care. Please sign below if you are happy for us to do this.

Signed ..... Date .....