centre dentaire dr. christian BERTRAND

DETAILED REPORT

Date: _____

Patient's name: _____ Date of birth: _____

Referent: _____

This report has three parts. The first part has three chapters that we will ask you to fill out. These chapters are: I. MAIN COMPLAINT, II. HISTORY OF SYMPTOMS, III. PATIENT'S MANDATE. We will ask you to sign at the end of this first part. The second part contains chapters 4 and 5 which are EXAM and DIAGNOSIS. The third part contains chapters 6 and 7 that are TREATMENT PLAN and PROGNOSIS. We will ask you to please sign this part as well, but only after the examination and after we have given you our recommandations.

I • MAIN COMPLAINT

What brings you to our office?

_____

_____

_____

II • HISTORY

1. WHAT KIND OF SYMPTOMS DO YOU HAVE?

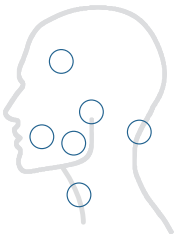
Headache	☐ Yes	☐ No	☐ Sometimes
Migraine	☐ Yes	☐ No	☐ Sometimes
Neck	☐ Pain	☐ Tension	☐ Fatigue
Jaw (articulation)	☐ Pain	☐ Tension	☐ Fatigue
Jaw (muscles)	☐ Pain	☐ Tension	☐ Fatigue
Face	☐ Pain	☐ Tension	☐ Fatigue
Shoulder	☐ Pain	☐ Tension	☐ Fatigue
Upper back	☐ Pain	☐ Tension	☐ Fatigue
Vertigo	☐ Yes	☐ No	

Describe: _____

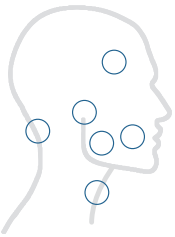
Teeth	☐ Yes	☐ No	☐ Sometimes	Describe: _____
Ears	☐ Yes	☐ No	☐ Sometimes	Describe: _____
Tinnitus	☐ Yes	☐ No	☐ Sometimes	Describe: _____
Eyes	☐ Yes	☐ No	☐ Sometimes	Describe: _____
Fibromyalgia	☐ Yes	☐ No	☐ Sometimes	Describe: _____

2. PUT AN "X" ON REGIONS AFFECTED BY PAIN

LEFT



RIGHT



II • HISTORY OF SYMPTOMS [continued]

3. PAIN LEVEL

Indicate your pain level between 0 and 10 (0 = absence of pain, 10 = Intolerable pain)

	Best moment	Worst moment	On average
Headache	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Migraine	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Neck/throat	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Jaw (articulation)	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Jaw (mucles)	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Teeth	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Ear	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Face	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Shoulder	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Upper back	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

4. HISTORY OF PAIN

Headache	☐ Constant	☐ Intermittent	Since: _____
	Frequency: _____		
Migraine	☐ Constant	☐ Intermittent	Since: _____
	Frequency: _____		
Neck/throat	☐ Constant	☐ Intermittent	Since: _____
Jaw	☐ Constant	☐ Intermittent	Since: _____
Teeth	☐ Constant	☐ Intermittent	Since: _____
Ear	☐ Constant	☐ Intermittent	Since: _____
Face	☐ Constant	☐ Intermittent	Since: _____
Shoulder	☐ Constant	☐ Intermittent	Since: _____
Upper back	☐ Constant	☐ Intermittent	Since: _____
Vertigo	☐ Constant	☐ Intermittent	Since: _____

5. QUALITY OF PAIN

Headache	☐ Throbbing pain	☐ Burning	☐ Deep pain
Migraine	☐ Throbbing pain	☐ Burning	☐ Deep pain
Neck/throat	☐ Throbbing pain	☐ Burning	☐ Deep pain
Jaw	☐ Throbbing pain	☐ Burning	☐ Deep pain
Teeth	☐ Throbbing pain	☐ Burning	☐ Deep pain
Ear	☐ Throbbing pain	☐ Burning	☐ Deep pain
Face	☐ Throbbing pain	☐ Burning	☐ Deep pain
Shoulder	☐ Throbbing pain	☐ Burning	☐ Deep pain
Upper back	☐ Throbbing pain	☐ Burning	☐ Deep pain
Vertigo	☐ Throbbing pain	☐ Burning	☐ Deep pain

Describe: _____

II • HISTORY OF SYMPTOMS [continued]

6. WHEN ARE THE PAIN WORST?

Headache	☐ Waking up	☐ Before noon	☐ After noon	☐ Evening	☐ Night
Migraine	☐ Waking up	☐ Before noon	☐ After noon	☐ Evening	☐ Night
Neck	☐ Waking up	☐ Before noon	☐ After noon	☐ Evening	☐ Night
Jaw	☐ Waking up	☐ Before noon	☐ After noon	☐ Evening	☐ Night
Ear	☐ Waking up	☐ Before noon	☐ After noon	☐ Evening	☐ Night
Face	☐ Waking up	☐ Before noon	☐ After noon	☐ Evening	☐ Night
Shoulder	☐ Waking up	☐ Before noon	☐ After noon	☐ Evening	☐ Night
Upper back	☐ Waking up	☐ Before noon	☐ After noon	☐ Evening	☐ Night
Vertigo	☐ Waking up	☐ Before noon	☐ After noon	☐ Evening	☐ Night

7. WHAT INCREASES OR REDUCES YOUR PAIN?

☐ Chewing	☐ increases	☐ reduces
☐ Talking	☐ increases	☐ reduces
☐ Opening your mouth	☐ increases	☐ reduces
☐ Swallowing	☐ increases	☐ reduces
☐ Eating something hard	☐ increases	☐ reduces

8. MEDICATION

What have you used in the past?

	Name	Dose	Frequency	Prescribed by
☐ Pain killer				
☐ Anti-inflammatory				
☐ Muscle relaxant				
☐ Sleep medication				
☐ Anxiolytic				
☐ Anti-grinding agent				
☐ Antidepressant				
☐ Other				

What do you use now?

	Name	Dose	Frequency	Prescribed by
☐ Pain killer				
☐ Anti-inflammatory				
☐ Muscle relaxant				
☐ Sleep medication				
☐ Anxiolytic				
☐ Anti-grinding agent				
☐ Antidepressant				
☐ Other				

II • HISTORY OF SYMPTOMS [continued]

9. HAVE YOU NOTICED SWELLING?

If yes, where? _____

10. BLOCKAGE

CLOSED ☐ Currently ☐ In the past

Since when (date) ____/____/_____/

Is it painful? _____ Which side is blocked? _____

How do you unlock? _____

What causes the blockage? _____

OPEN ☐ Currently ☐ In the past

Since when (date) ____/____/_____/

Is it painful? _____ Which side is blocked? _____

How do you unlock? _____

What causes the blockage? _____

11. LIMITED OPENING?

☐ Now Since when? _____

What helps? _____

What harms? _____

☐ In the past This occurred when? _____

What helped? _____

What harmed? _____

12. JOINTS NOISES

		Now	In the past
RIGHT:	Clicking	☐	☐
	Crepitus	☐	☐
	No noise	☐	☐

Noises started (date) ____/____/_____/ Is it painful? _____

When did it change? _____

Is there a correspondence between a change in noise level and onset or disappearance of pain?

Describe: _____

		Now	In the past
LEFT:	Clicking	☐	☐
	Crepitus	☐	☐
	No noise	☐	☐

Noises started (date) ____/____/_____/ Is it painful? _____

When did it change? _____

Is there a correspondence between a change in noise level and onset or disappearance of pain?

Describe: _____

II • HISTORY OF SYMPTOMS [continued]

13. HAVE YOU NOTICED CHANGES IN YOUR BITE?

Describe the changes: _____

_____

If yes, since when? _____

Is it progressive? _____

Did it happen abruptly? _____

Are you aware of a cause? _____

14. HAVE YOU NOTICED CHANGES IN YOUR FACE?

☐ Swelling
☐ Chin drifts
☐ Chin receding
☐ Other: _____

15. HAVE YOU NOTICED CHANGES IN YOUR TEETH POSITION?

☐ yes, describe: _____
☐ no

16. ARE YOU AWARE OF CLENCHING OR GRINDING YOUR TEETH?

☐ At night
☐ Day time
☐ Stressful moment

Is there an apparent cause? _____

Since when are you aware of it? _____

17. OVERUSE

☐ Chewing gum
☐ Biting nails
☐ Constant clenching
☐ Speak all day long at work

Your job: _____

18. WHERE YOUR TONGUE IS POSITIONED IN YOUR MOUTH?

☐ Between upper and lower teeth
☐ It's touching my upper front teeth
☐ It's touching my lower front teeth
☐ In my palate

19. WHEN YOU CLOSE YOUR TEETH TOGETHER, ON WICH SIDE YOU FEEL MORE PRESSURE?

☐ right ☐ left ☐ equal

20. ARE YOUR TEETH SENSITIVE?

☐ yes Since when? _____ To what? _____
☐ no

21. DO YOU HAVE A TENDANCY TO FRACTURE YOUR TEETH OR YOUR FILLINGS?

☐ yes ☐ no

22. SPORTS

What sport did you practice or do you practice?

During childhood: _____

During adolescence: _____

During adulthood: _____

23. TRAUMA

Has your jaw ever been knocked, even lightly (ball, fall, etc…)? ☐ yes ☐ no

Your head? ☐ yes ☐ no

Have you ever had a concussion? ☐ yes ☐ no

Have you been involved in a car accident?

☐ yes ☐ With injuries ☐ Whiplash

☐ no

Have you ever bumped your teeth? ☐ yes ☐ no

Do you have scars on your face?

☐ yes ☐ chin ☐ forehead ☐ head

☐ no

Have you ever undergone surgery with general anesthesia?

☐ yes ☐ no

24. SLEEP APNEA

Are you prone to sleep apnea? ☐ yes ☐ no

Have you ever had an assessment regarding sleep apnea? ☐ yes ☐ no

Do you use a CPAP (positive pressure device)? ☐ yes ☐ no

Do you snore? ☐ yes ☐ no

Do you wake up rested in the morning? ☐ yes ☐ no

Do you feel tired during the day?
(e.g.: end of afternoon, during a reading, driving…) ☐ yes ☐ no

25. HAVE YOU EVER HAD A CARE OF:

☐ Orthodontics (braces)

☐ Night guard

☐ Teeth equilibration

☐ Jaw surgery

☐ None

II • HISTORY OF SYMPTOMS [continued]

26. HAVE YOU EVER RECEIVED CARE FOR WHAT YOU ARE CONSULTING FOR TODAY?

☐ Physiotherapy/osteopathic treatment/chiropractic/other: _____

When? _____ Did it help? ☐ yes ☐ no

☐ Medication When? _____ Did it help? ☐ yes ☐ no

☐ Night guard When? _____ Did it help? ☐ yes ☐ no

☐ Orthodontics When? _____ Did it help? ☐ yes ☐ no

☐ Surgery When? _____ Did it help? ☐ yes ☐ no

Have you ever been informed about the nature of your problem? The cause?

_____

_____

_____

27. WHAT TYPE OF PRACTITIONER HAVE YOU CONSULTED?

☐ Dentist
☐ Specialist
☐ Doctor
☐ ENT
☐ Neurologist
☐ Surgen
☐ Pain clinic
☐ Migraine clinic
☐ Psychologist
☐ other

28. YOUR STRESS LEVEL

	Yes	No
Are you currently experiencing a period of stress?	☐	☐
Are your symptoms related to periods of stress?	☐	☐
Are you anxious?	☐	☐
Have you ever been treated for anxiety/depression?	☐	☐
Are you currently?	☐	☐

29. LEVEL OF CONCERN

Does your condition cause anxiety?
(0 being no worries and 10 being the maximum)

☐ yes If so, at what level? **0 1 2 3 4 5 6 7 8 9 10**

☐ no

III • PATIENT'S MANDATE

WHAT IS YOUR GOAL BY COMING TO SEE US?

WHAT WOULD YOU LIKE FROM US?

WHAT ARE YOUR EXPECTATIONS?

A) concerning today's visit

B) from our care

C) from your situation

I answered this questionnaire to the best of my knowledge.

Patient signature