ADULT PATIENT QUESTIONNAIRE

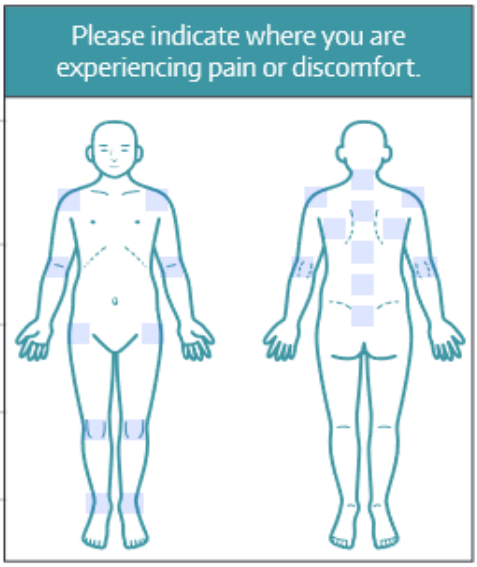
CONFIDENTIAL PATIENT INFORMATION

Full Name:
Street Address: City, State, Postal Code:
Cell Phone: Other Phone: Child's Sex: ◯ M ◯ F
Email: Occupation: Birthdate: Age:
How did you hear about us?
Who is your primary care physician?
Are you receiving care from any other health professionals? ◯ Yes ◯ No
-If yes, please name them and their specialty:
Please list and drugs/medications/vitamin/herbs/other that you are taking:

CURRENT HEALTH CONDITIONS

What health condition(s) bring your you to be evaluated?
When did the conditions first begin? How did the problem start? ◯ Suddenly ◯ Gradually Post-Injury
Has your child ever received care for this condition before? ◯ Yes ◯ No
-If yes, please explain:

Is this condition: ◯ Getting Worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure
What makes the problem better? What makes the problem worse?
Have you ever been assessed for oral ties by a professional?
Have you ever seen any other alternative specialists? If yes, please explain:



LABOR AND DELIVERY

You were Birthed: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section At how many weeks were you born?
You birth was: ◯ At home ◯ At a birthing center ◯ At a hospital ◯ Other: Doctor/Obstetrician/Midwife Name:
Please check any applicable interventions or complications:
◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps ◯ Other:_____
Were you in the NICU: ◯ Yes ◯ No
How was the umbilical cord at birth: ◯ Unwrapped loosely ◯ tightly ◯ knotted ◯ unknown

HEALTH GOALS

What are your top three health goals:

1. _____
2. _____
3. _____

What would you like to gain?

- ◯ Resolve existing condition
- ◯ Overall wellness
- ◯ Both

Oral Health

Do you see a dentist regularly? Yes No

Have you ever had any of the following: Cavities Root Canal Braces Surgeries

-If yes please explain how many and procedures:

Signature_____ Date:_____/___/_____