Welcome to our office! Below you will be answering questions that will help us tailor your treatment to fit your specific needs. Never hesitate to ask any questions!

Name:_____ **Birthday:**_____

CHIEF COMPLAINT: Check all that apply.

- ☐ Snoring
- ☐ CPAP Intolerance
- ☐ Dry Mouth
- ☐ Waking up gasping for air
- ☐ Pain – location?_____
- ☐ Morning Headaches
- ☐ Ehlers Danlos
- ☐ Nasal Congestion
- ☐ Difficulty concentrating
- ☐ Clinching/Grinding Teeth
- ☐ Fatigue
- ☐ Insomnia
- ☐ Morning headaches
- ☐ Impaired thinking
- ☐ Witnessed cessation of breathing
- ☐ Other_____

Have you completed a sleep study? YES or NO

If yes, who was the doctor_____ **Date of Treatment**_____

C-PAP ISSUES:

- ☐ No history of a CPAP
- ☐ Pressure Intolerance
- ☐ Poor Mask Fit
- ☐ Mouth Leaks
- ☐ Inconvenience
- ☐ Other_____

Height_____ **Weight**_____

Name of Dentist_____

Do you have any pending dental treatment? YES or NO

If yes, what treatment is needed? _____

elements DENTAL

SLEEP QUESTIONAIRE

NAME:_____ DATE___/___/_____

Have you been previously diagnosed with Obstructive Sleep Apnea? **YES or NO**

If yes, how long ago was it? _____ **Years/Months/Days**

What time do you normally go to bed? _____

What time do you normally wake up? _____

Do you use an alarm clock to wake up? **YES or NO**

Do you use a Sleep Aid? **YES or NO**
If yes, what? _____

On average how many hours do you sleep per night? _____

How long does it take you to fall asleep?
Almost instantly **10-15 mins** **30mins** **1 hour** **2+ hours**

How many times do you awaken on a typical night of sleep?
0 **1** **2** **3** **4** **5**

Snoring is reported as –
Seldom **Never** **Daily** **Often**

Severity –
Light **Moderate** **Loud**

Do you awake refreshed? **YES or NO**

Do you awake with morning headaches? **YES or NO**

SLEEP QUESTIONAIRE

NAME:_____ DATE___/___/_____

Have you been previously diagnosed with Obstructive Sleep Apnea? **YES or NO**

If yes, how long ago was it? _____ **Years/Months/Days**

What time do you normally go to bed? _____

What time do you normally wake up? _____

Do you use an alarm clock to wake up? **YES or NO**

Do you use a Sleep Aid? **YES or NO**
If yes, what? _____

On average how many hours do you sleep per night? _____

How long does it take you to fall asleep?
Almost instantly 10-15 mins 30mins 1 hour 2+ hours

How many times do you awaken on a typical night of sleep?
0 1 2 3 4 5

Snoring is reported as –
Seldom Never Daily Often

Severity –
Light Moderate Loud

Do you awake refreshed? **YES or NO**

Do you awake with morning headaches? **YES or NO**

TMJ QUESTIONAIRE

Do you have pain in the face, shoulders or neck?	YES	NO
Do you have frequent headaches?	YES	NO
Do you have recurring tooth pain or sensitivity?	YES	NO
Do you have ringing fullness or pain in your ears?	YES	NO
Do you have difficulty opening your mouth or does your jaw get "stuck or "locked"?	YES	NO
Do you grind or clinch your teeth?	YES	NO
Do you have arthritis?	YES	NO
Have you had any previous treatment for your jaw joint (TMJ problem)?	YES	NO

If so, when and by whom? _____

Do you have difficulty swallowing?	YES	NO