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519-266-3600
Email: info@sclondon.ca
Website: www.sclondon.ca

Patient questionnaire *In order to provide you with the most appropriate treatment, please complete the following questionnaire.* All information is strictly confidential and for our records only.

Last Name: _____ First Name: _____
Address: _____City/Town:_____
Postal Code: _____ Date of Birth: D_____M_____YR_____Age: _____
Telephone: (_____) _____ Cell: (_____) _____
Work: (_____) _____ Other: (_____) _____
Preference of which number to call you: _____ May we leave a message? Y / N
Email: _____
Emergency Contact: _____Relationship: _____Tel#_____
How were you referred to us? Friend or Family / Facebook / Website / Advertisement / Mail / Physician / Signage / Other: _____

Medical History

Do you have or had any of the following?

AIDS/ HIV	Y / N	Fainting Spells	Y / N	Radiation Treatment	Y / N
Alzheimer's	Y / N	Fever Blisters	Y / N	Recent Weight Loss	Y / N
Anaphylaxis	Y / N	Frequent Diarrhea	Y / N	Recent Weight Gain	Y / N
Anemia	Y / N	Frequent Headaches	Y / N	Renal Dialysis	Y / N
Angina	Y / N	Genital Herpes	Y / N	Rheumatic Fever	Y / N
Anxiety	Y / N	Glaucoma	Y / N	Rheumatism	Y / N
Arthritis	Y / N	Gout	Y / N	Scarlet Fever	Y / N
Artificial Heart Valve	Y / N	Hay Fever	Y / N	Shingles	Y / N
Artificial Joints	Y / N	Heart Attack/ Failure	Y / N	Sickle Cell	Y / N
Asthma	Y / N	Heart Pacemaker	Y / N	Sinus Infections /Trouble	Y / N
Blood Disease	Y / N	Heart Trouble/Disease	Y / N	Spina Bifida	Y / N
Blood Transfusion	Y / N	Hemophilia	Y / N	Stomach Disease	Y / N
Breathing Problems	Y / N	Hepatitis A, B, C	Y / N	Stroke	Y / N
Bruise Easily	Y / N	High Blood Pressure	Y / N	Swelling of Limbs	Y / N
Cancer	Y / N	HPV	Y / N	Thyroid Disease	Y / N
Chemotherapy	Y / N	Immunocompromized	Y / N	Tonsillitis	Y / N
Chest Pains	Y / N	Insomnia	Y / N	Tuberculosis	Y / N
Cold Sores	Y / N	Intestinal Disease	Y / N	Tumors / Growths	Y / N
Congenital Heart Disorder	Y / N	Jaundice	Y / N	Ulcers	Y / N
Convulsions	Y / N	Lung Disease	Y / N	Venereal Disease	Y / N
Cortisone Medicine	Y / N	Mitral Valve Prolapse	Y / N	Vertigo	Y / N
Diabetes	Y / N	Muscle Cramps	Y / N	Other: _____	
Depression	Y / N	Motor Vehicle Accident	Y / N		
Dizziness	Y / N	Nausea	Y / N	Women Only :	
Drug Addiction	Y / N	Nervousness	Y / N	Pregnant?	Y / N
Easily Winded	Y / N	Pain in Jaw Joints	Y / N	Trying to get Pregnant?	Y / N
Emphysema	Y / N	Panic Attacks	Y / N	Taking Birth Control?	Y / N
Epilepsy/Seizures	Y / N	Parathyroid Disease	Y / N		
Excessive Bleeding	Y / N	Phobias	Y / N		
Excessive Thirst	Y / N	Psychiatric Care	Y / N		

Personal Habits or Occurrences

Chew gum?	Y / N	In Past / Currently	Per Day / Week: _____
Eat Candy?	Y / N	In Past / Currently	Per Day / Week: _____
Consume Soft Drinks?	Y / N	In Past / Currently	Per Day / Week: _____
Consume Coffee?	Y / N	In Past / Currently	Per Day / Week: _____
Consume Alcohol?	Y / N	In Past / Currently	Per Day / Week: _____
Smoke Cigarettes?	Y / N	In Past / Currently	Per Day / Week: _____
Smoke Cigars/ Other?	Y / N	In Past / Currently	Per Day / Week: _____
Suck on Thumb/fingers?	Y / N	In Past / Currently	Per Day / Week: _____
Bite Nails/Other(ie. pens)?	Y / N	In Past / Currently	Per Day / Week: _____
Wake up Tired?	Y / N	In Past / Currently	Per Week / Mth: _____
Low Energy During Day?	Y / N	In Past / Currently	Per Week / Mth: _____
Trouble Concentrating?	Y / N	In Past / Currently	Per Week / Mth: _____
Do you wear a Night guard	Y / N	In Past / Currently	Per Week / Mth: _____
Do you use a CPAP for Sleep	Y / N	In Past / Currently	Per Week / Mth: _____
Wake Often During Sleep?	Y / N	Times per sleep: _____	Avge Hours of Sleep per night _____

Are there any other habits we should be aware of? Y / N If Yes, Please Explain: _____
_____

How many glasses of water do you consume per day on average? _____
How often are you involved in exercise per week? _____ What activities? _____
Please describe to us your eating habits on a daily basis: _____
_____
_____
_____
List out your medications/ vitamins consumed. Include dose and frequency: _____
_____
_____

Are you under a Physician's care now? Y / N If Yes, Please Explain: _____
Hospitalized or had Major Operations? Y / N If Yes, Please Explain: _____
Serious Head or Neck Injury? Y / N If Yes, Please Explain: _____
Taking any Medications, Pills, Drugs? Y / N If Yes, Please Explain: _____
_____
_____

Are you on a Special Diet? Y / N If Yes, Please Explain: _____
Do you have any Allergies Y / N If Yes, Please Explain: _____
_____
_____

Synergy / Doctor Notations Only:
_____
_____
_____
_____
_____

Musculoskeletal Screening

Pain in Jaw and Joints? __ L R __

Pain in ear? __ L R __

Pain around eyes? __ L R __

Pain in lower jaw? __ L R __

Pain in upper jaw? __ L R __

Pain in neck? __ L R __

Pain in shoulder? __ L R __

Pain in forehead? __ L R __

Pain in temples? __ L R __

Pain in facial muscles? __ L R __

Grating sound in joint? __ L R __

Subjective hearing loss? __ L R __

Clicking, snapping, popping sound in joint? __ L R __

Ringing in ears? __ L R __

Fullness or, pressure blockage in ear? __ L R __

Pain in tongue? Y / N

Limited Mouth Opening? Y / N
If yes, Partially? Severe?
If yes, Constant? Sporadic?

Difficulty chewing? Y / N

Change in chewing? Y / N

Difficulty swallowing? Y / N

Change in swallowing? Y / N

Snoring? Y / N

Constantly tired? Y / N

Mouth Breathe at night? Y / N

Awaken with a dry mouth? Y / N
If yes, Frequently? Rarely?

Tingling in Finger Tips? Y / N

Postural Problems? Y / N

History of Clenching Teeth? Y / N

History of Grinding Teeth? Y / N

Loose Teeth? Y / N

Sensitive Teeth? Y / N
If yes, Constant? Sporadic?
If yes, Hot? Cold? Other?

To the best of my knowledge, the Questions on this form have been accurately answered.

I,_____ understand that providing incorrect information can be dangerous to my health.

I, _____ recognize it is my responsibility to inform Synergy Centre of any changes to my medical history or personal lifestyle that may or may not be relevant to the care received by any of the doctors, or team members of Synergy Centre. I understand that I am encouraged to ask as many questions as required in order for me to decide the course of care I decide to go forward with.

Patient's Printed Name: _____Patient's Signature: _____

Date: _____ Treatment Co/ordinator: _____

Dr. Maria Tetelbaum: _____Dr. Octavian Tetelbaum: _____

Synergy Team / Doctor Notations Only:

_____
_____
_____
_____
_____
_____
_____

Headache History

1. A. How many days in the past month did you spend without any headache/migraine pain of any kind? Headache free-days? _____day(s) this past month. Number less than 15? Y / N

   B. How many days in the past month did you spend with headache/ migraine pain? Count ALL days with any headache pain of any kind, even those for which you didn't feel the need to take any medication. _____day(s) this past month. Number more than 15? Y / N

2. Did any of your headaches/migraines last more than 4 hours if you didn't treat them? Y / N

3. Have you ever been diagnosed as having chronic headaches? Y / N
   (including chronic tension-type or chronic sinus headaches)

4. Have you ever been diagnosed as having migraines? Y / N

5. Do your headaches/migraines impact your daily life? Y / N

   Rate the impact of your headaches/migraines on your daily life:

   Mild 1 2 3 4 5 6 7 8 9 10 Severe

6. How many days in the past moth have your headaches/migraines severely affected your daily affected your daily life? _____day(s) in the past month.
7. In the past month, did you take including over-the-counter drugs, prescription medication, and herbal remedies to treat your headaches/migraines? Y / N
   If Yes, Please how many days in the past month did you take something to treat your headaches/migraines?_____day(s) in the past month.
   Accurately list what you took: _____
   _____
8. In your words please describe the headaches you are experiencing: _____
   _____
9. What treatments have you tried in order to relieve/resolve your symptoms: _____
   _____
10. What NEW treatments have you recently heard of for headaches/ migraines that you would like to know more about? _____
    _____

Epworth Sleepiness Scale

0= Would never feel tired, 1 = Light Chance of feeling tired, 2 = Moderate Chance, 3 = High Chance

How Tired would you become?		Enter score		
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place for example, a theatre or meeting	0	1	2	3
Lying down to rest in the afternoon, when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (without drinking any alcohol)	0	1	2	3
In a car, while stopping for a few minutes in traffic	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3

Total Score: _____