Healthworks
NUTRITION CENTRE

Date of Exam_____

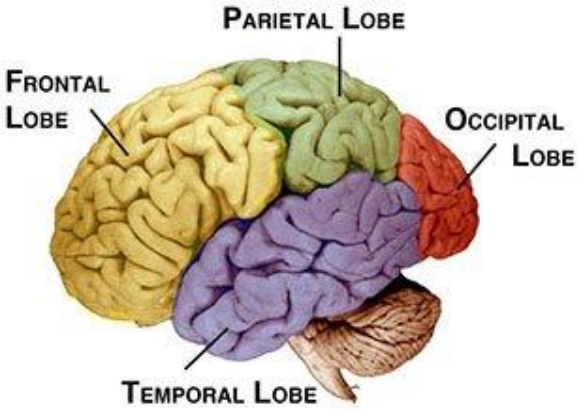
Cranial/Dental Health History – Initial

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ Postal Code: _____

Cell: _____ Home: _____ E-mail: _____

Occupation: _____ Marital Status: S M D W SEP # of Children: _____



Yes/No Headaches?
Please circle: Dull/Sharp/Cluster/Sinus/Other

Describe other: _____

_____

Which side? Right side/Left side

Which lobe? *(see diagram to the left, circle below)*

Frontal *(top front)*/ Parietal *(top back)*/
Temporal *(side)* / Occipital *(back)*

Yes/No Nasal Condition? Right side/Left side

Yes/No Allergies?
Type? Seasonal Hay Fever / Food / Dust / Mold / Pets / Unknown

Yes/No Have you ever been diagnosed with Cerebral Circulatory Problems?
Please explain: _____

Yes/No Have you been diagnosed with a thyroid condition?
Which? Hypo / Hyper
Type? Hashimoto's / Grave's / Goiter / Cancer / Unknown

Yes/No Other Conditions?
Describe: _____

_____

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Yes/No Do you have a specific dental problem?

Describe: _____

Yes/No Do you have dental examinations on a routine basis?

Date of last visit: _____

Please indicate if you have any of the following conditions:

Yes/No Have you ever been diagnosed with Temporomandibular Joint Disorder (TMJ)?

Yes/No Root Canal Treatments ❒ Upper Left ❒ Upper Right
❒ Lower Left ❒ Lower Right

Yes/No Do your gums ever bleed?

Yes/No Do you clench or grind your teeth?

Yes/No Does your jaw hurt or click? ❒ R ❒ L

Yes/No Do you have any difficulty chewing?

Yes/No Do you think you have active decay or gum disease?

Please note any other concerns/issues you may have:

_____

_____

_____

GENERAL HEALTH INFORMATION

Do you have any medical complaints or conditions? Yes/No

Please explain: _____

_____

Are you currently taking any medications? Yes/No

Please list: _____

_____

Signature: _____ Date: _____