TMD & SLEEP PROGRESS REPORT

1. What has been the level of your head, ear or facial pain since your last visit? **(0 – none, 1- lowest, 10 – highest)**

Circle your choice of: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

2. What has improved since your last visit?_____
3. What other areas of your body continue to be painful? _____
4. What has been your chief complaint(s) since your **last** visit? _____
5. What medications are you taking for relief of pain? _____
6. Is it easy to fall asleep? _____Do you wake during the night? _____Do you feel rested upon AM waking?____
7. On average, in a 24 hour day, I have worn my appliances: _____hours/day _____hours/night
8. When do you remove your appliance(s)?_____
9. Do you feel our treatment is helping you? ☐ YES ☐ NO
10. If you are presently going to a chiropractor, massage therapist, or physical therapist, do you feel that the therapy is helping you? ☐ YES ☐ NO

Patient Name **Patient Signature** **Date**

OFFICE USE ONLY

***NOTES for review of #1-10 above**: _____

_____

_____

Current Vitals: Blood Pressure _____ **Heart Rate** _____

ROM W/O ORTHOTIC

Interincisal Opening _____mm
Lateral Excursion Rt _____mm
Lateral Excursion Lt _____mm
Protrusive _____mm

Cervical ROM

Seated Left Rotation _____°
Seated Right Rotation _____°
Flexion _____° Extension _____°

ORTHOTIC CHECK

Day Appliance Insert/Reline/Adjust
Night Appliance Insert/Reline/Adjust

Parachute Test:		Wall Test:	
Day Orthotic	**Night Orthotic**	**Day Orthotic**	**Night Orthotic**
+ - w/o Appliance	+ - w/o Appliance	+ - w/o Appliance	+ - w/o Appliance
+ - w/ Appliance	+ - w/ Appliance	+ - w/ Appliance	+ - w/ Appliance

Chief Complaints:

1. _____
2. _____
3. _____
4. _____
5. _____

Resolved or Recommendations:

1. _____
2. _____
3. _____
4. _____
5. _____

COMPLIANCE: ORTHOTIC WEAR:_____ MEDS:_____ REFERRAL:_____

ADDITIONAL NOTES:_____

_____

_____

Review of Meds:_____

TREATMENTS:

Trigger Point Sites: _____ = Delivered Meds: **.5cc** Sarapin **.5cc** Depomedrol **1.5cc** Procaine 1%

Prolo Therapy sites: _____ = Delivered Meds: **.5cc** Dextrose 50% **.5cc** BacH2O **1.5cc** Lidocaine 2%

LASER: C-Spine/Traps TM/Masseter LI4 Other PMT _____

Post Treatments - Percent reduction of symptoms reported by patient: _____

Assistant: _____ **Seen by:** _____

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OAT FOR SLEEP APNEA PROGRESS REPORT

1. How would you rate the current quality of your sleep? **(0 - 3 = poor 4 - 7 = improved 8 - 10 = excellent)**

Circle your choice of: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

2. Is it easy to fall asleep? ☐ YES ☐ NO
3. Do you wake during the night? ☐ YES ☐ NO number of times = _____
4. Do you wake feeling rested/refreshed? ☐ YES ☐ NO
5. Do you wear your appliance every night? ☐ YES ☐ NO hours of wear/night = _____
6. What has improved since your last visit? _____
7. What has been your chief complaint(s) since your **last** visit? _____
8. Have you had a change in medication(s) since beginning therapy? ☐YES ☐ NO

_____

9. Do you feel our treatment is helping you? ☐YES ☐NO

Patient Name	Patient Signature	Date
_____	_____	_____

OFFICE USE ONLY

****NOTES for review of #1-9 above:** _____

_____

_____

Appliance Delivery Date _____ **Pre-Treatment AHI** _____ **RDI** _____

Post Delivery Eval # ☐1 ☐2 ☐3 ☐4 ☐5 ☐ 6

☐ **Follow-up Sleep Test Consult** ☐ **Biannual Re-evaluation**

Current Vitals: Blood Pressure _____ **Heart Rate** _____

ROM W/O APPLIANCE

Interincisal Opening _____mm
Lateral Excursion Rt _____mm
Lateral Excursion Lt _____mm
Protrusive _____ mm

Cervical ROM

Seated Left Rotation _____°
Seated Right Rotation _____°
Flexion _____° Extension _____°

APPLIANCE CHECK

Parachute Test: for Sleep Appliance	Wall Test for Sleep Appliance
+ - w/ Appliance	+ - w/ Appliance
+ - w/o Appliance	+ - w/o Appliance

Chief Complaints:

1. _____
2. _____
3. _____
4. _____

Resolved or Recommendations:

1. _____
2. _____
3. _____
4. _____

ADDITIONAL ASSESSMENT NOTES: _____

_____

_____

PLAN / TITRATION: _____

_____

_____

_____

LASER: C-Spine/Traps TM/Masseter LI4 Other PMT _____

Post Treatments - Percent reduction of symptoms reported by patient: _____

Assistant: _____ **Seen by:** _____

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