HEALINGSPACE
medical center

Confidential Questionnaire

Head and Neck Screening

Name

Birth Date Today's Date

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner you specify.

Head & Neck

	Yes	No
1. Do you suffer with headaches?	○	○
If yes, ○ once a month or less ○ more than once a month		
2. Do you have known allergies? Food ____ Environmental___ ○	○	
3. Do you have TMJ, or does your jaw click?	○	○
4. Do you currently have a cold?	○	○
5. Are you being treated for a thyroid disorder? Type_____	○	○
6. Do you have neck pain?	○	○
7. Do you have upper back pain?	○	○
8. Do you have a known history of carotid artery disease?	○	○
9. Do you have a family history of stroke?	○	○
10. Do you currently suffer from sinus problems?	○	○
11. Do you have a history of dental problems?	○	○
Root canals ____ Gum disease ____ Implants ____		
Non-replaced extractions ____ Dentures ____		
12. Have you had a dental cleaning in the past 7 days?	○	○

Do you have any special concerns or are there any details related to the information above?