Patient's Details

Title: (Eg: Mr/Mrs/Miss/Ms)_____ Family Name: _____

Date of birth: __/__/_____ Given Name: _____

Home address: _____ Postcode: _____

_____

Postal address: _____ Postcode: _____

_____

Ph (hm): _____ Ph (wk): _____ Mob: _____

Email address: _____

Are you happy to receive email and/or SMS notification Yes ☐ No ☐

Emergency contact details: _____ Ph: _____

Parent / Guardian details (required if patient is under the age of 18)

Family Name: _____ Given Name: _____

Home Address:_____ Postcode: _____

_____

Ph (Hm): _____ Ph (wk): _____

Mob: _____ Email: _____

Other family members that are patients of Symmetry Dental?

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Medical History

Name of GP: _____ GP's contact number: _____

GP practice name: _____

Are you, or do you suspect you may be, pregnant? _____

Do you smoke? _____

Do you suffer from Sleep Apnoea? _____

Do you suffer from snoring? _____

Is your blood pressure normal, high or low? _____

Are you currently taking medication for osteoporosis? _____

Have you had any serious illnesses in the last 2 years? *If yes, please provide more information.*

_____

_____

Does dental treatment make you nervous? No ☐ Slightly ☐ Moderately ☐ Extremely ☐

- I, the undersigned, consent to the performance of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics as indicated, and I will assume responsibility for the fees associated with those procedures.
- I hereby consent to the use of any study models, x-rays, computer images and photographs at various dental seminars, lectures, and publications that the dentists may author.
- I understand that the practice requires a minimum 24 hours notice if I need to cancel my scheduled appointment and that a cancellation fee could be incurred if I fail to do so.
- I am aware that payment is required on the day of treatment.

X_____ _____
Patient Signature **Date of signature**

CRANIOFACIAL PAIN, HEADACHE, TMJ AND SLEEP DISORDERS

PATIENT INFORMATION AND HISTORY

Name:_____
Date:_____

INSTRUCTIONS: Please answer all questions as accurately and thoroughly as possible. The completeness of your answers directly affects the diagnostic decisions made on your behalf. Although some questions may not seem applicable to you, there is a specific reason behind each question asked. This information will remain confidential at all times.

We realise that it will take considerable time to complete this form. We can assure you this information will be reviewed in detail before, during and after your examination.

Head and neck pain, especially temporomandibular joint dysfunction, has many causes and symptoms. As such, a thorough diagnosis is most important for a successful outcome.

Please describe the problem(s) you have with your head, neck, face or jaw in your own words. From the beginning of your problem(s) to the present time, try to place the events in chronological order. Should additional space be required, please feel free to attach a separate sheet or continue on the back of this one.

1. What started or set off the problem(s)?_____

2. What do you do to control your pain or dysfunction?_____

3. Does any member of your family have the same or similar problem(s)? Yes ☐ No ☐

   Please explain:_____

4. Realising that you are visiting this office for diagnosis and treatment of your problem(s), do you have an opinion about what should be done to correct your present condition?_____

   _____

   _____

5. Are you receiving or applying for disability? Yes ☐ No ☐

6. Are you now, or are you planning to be involved in litigation relating to your problem(s)? Yes ☐ No ☐

If so, please supply Solicitor name and phone #: _____

Referral Information

Who referred you to this practice?

DENTAL HISTORY: *Please mark the box in the appropriate column indicating whether or not you presently have, had in the past, or never had any of the following conditions or symptoms.*

NEVER	PAST	PRESENT	
☐	☐	☐	Have you ever had periodontal (gum) disease?
☐	☐	☐	Oral Surgery
☐	☐	☐	Wisdom teeth removed
☐	☐	☐	Grind ☐ or Clench teeth ☐
☐	☐	☐	Bite adjusted by dentist
☐	☐	☐	Chew gum regularly – hours daily? _____
☐	☐	☐	Have you had orthodontic treatment? (Braces)
☐	☐	☐	- Did you have teeth removed for Ortho?
☐	☐	☐	- Did you wear head gear? Age? ____ Orthodontist name: _____
☐	☐	☐	Do you bite or chew fingernails?
☐	☐	☐	Are any of your teeth worn badly?
☐	☐	☐	Are any of your teeth loose?
☐	☐	☐	Accident to teeth? If so, how: _____
☐	☐	☐	Have you ever worn a Splint ☐ Retainer ☐ or Night guard ☐

FOR WOMEN:

YES	NO	
☐	☐	Do you have children? Age(s)? _____
☐	☐	Are you pregnant? Expected delivery date: _____
☐	☐	Do you have a history of miscarriages?
☐	☐	Are you taking birth control pills? For how long? _____
☐	☐	Do you experience irregular menstrual cycles? Have you had surgery of the female organs? (Including female ligation)
☐	☐	If you have children, were they difficult births?
☐	☐	Did you have a C-Section ☐ Episiotomy ☐ Tearing ☐
☐	☐	Have you reached Menopause? If so, are you taking supportive medication? _____
☐	☐	Have you been told, or do you suspect, you may have Pre-Menstrual Syndrome?

HISTORY OF TRAUMA: *Please fill in appropriate column.*

	YES	NO	
1.	☐	☐	Accident or trauma to head? If so, how: _____
2.	☐	☐	Accident or trauma to face? If so, how: _____
3.	☐	☐	Accident or trauma to jaw? If so, how: _____
4.	☐	☐	Accident or trauma to neck? If so, how: _____
5.	☐	☐	Whiplash neck injury? If so, how: _____
6.	☐	☐	Cervical traction neck collar? _____

JAW STRETCH OR STRAIN FROM:

	YES	NO	
1.	☐	☐	Surgery? _____
2.	☐	☐	Dental Procedure? _____
3.	☐	☐	Yawning? _____
4.	☐	☐	Other? Please explain: _____
5.	☐	☐	Broken Jaw? If so, how? _____
6.	☐	☐	Scar on or around your chin? _____
7.	☐	☐	Do you have any body piercings? _____

EYE SYMPTOMS: *Please mark the appropriate box and identify right or left side where indicated*

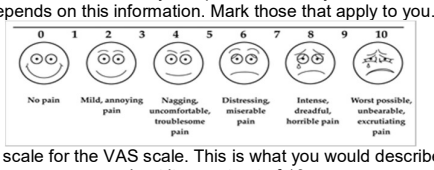
	YES	NO		RIGHT	LEFT
1.	☐	☐	Pain in, around or behind eyes?	☐	☐
2.	☐	☐	Eyelid twitches?	☐	☐
3.	☐	☐	Eyes blink or water most of the time?	☐	☐
4.	☐	☐	Eyesight blurs?	☐	☐
5.	☐	☐	Do you wear glasses?		
6.	☐	☐	Do you wear contact lenses?		

EAR SYMPTOMS: *Please mark the appropriate box and identify right or left side where indicated*

	YES	NO		RIGHT	LEFT
1.	☐	☐	Earaches or ear pain?	☐	☐
2.	☐	☐	Ringing, hissing or buzzing sounds in ear?	☐	☐
3.	☐	☐	Stuffiness or fullness in ears?	☐	☐
4.	☐	☐	Grating noise in ears?	☐	☐
5.	☐	☐	Throbbing or whooshing sound in ear?	☐	☐
6.	☐	☐	Hearing loss?	☐	☐

SYMPTOM SURVEY

Please take your time to accurately complete this survey. Your treatment success depends on this information. Mark those that apply to you.



Please use this scale for the VAS scale. This is what you would describe your level of pain at its worst out of 10.

Sign or Symptom	*VAS /10*	*Location*	*Onset*

YES	*NO*	*What are you experiencing?*	*Pain level out of 10*	*R-Right side L-Left side B-Both sides UML-Upper Middle Lower*	*How long have you had this problem?*
☐	☐	Back pain	__/10	☐U ☐M ☐L	_____
☐	☐	Clicking/Popping TMJ (Jaw joint)		☐R ☐L ☐B	_____
☐	☐	Difficulty Chewing			_____
☐	☐	Difficulty Closing Mouth			_____
☐	☐	Difficulty Opening Mouth			_____
☐	☐	Difficulty Swallowing			_____
☐	☐	Jaw Pain	__/10	☐R ☐L ☐B	_____
☐	☐	Ear Ringing &/or ☐ Fullness		☐R ☐L ☐B	_____
☐	☐	Eye Pain	__/10	☐R ☐L ☐B	_____
☐	☐	Facial Pain	__/10	☐R ☐L ☐B	_____
☐	☐	Fatigue	__/10		_____
☐	☐	Headaches	__/10	☐R ☐L ☐B	_____
☐	☐	Locked TMJ	__/10	☐R ☐L ☐B	_____
☐	☐	Migraine Headaches	__/10	☐R ☐L ☐B	_____
☐	☐	Neck Pain	__/10	☐R ☐L ☐B	_____
☐	☐	Numbness – Upper Limbs		☐R ☐L ☐B	_____
☐	☐	Shoulder Pain	__/10	☐R ☐L ☐B	_____
☐	☐	Sinus congestion		☐R ☐L ☐B	_____
☐	☐	Snoring/ Sleep Apnoea			_____
☐	☐	Ear Pain	__/10	☐R ☐L ☐B	_____
☐	☐	Vertigo/Dizziness			_____
☐	☐	Visual Disturbances		☐R ☐L ☐B	_____
☐	☐	Other: _____			_____

PSYCHOSOCIAL QUESTIONAIRE:

1. **Do you believe in your ability to reach your goals?**

Use 1-6 scale: 1=Strongly believe 6= No belief

☐1 ☐2 ☐3 ☐4 ☐5 ☐6

2. **Do you struggle to stay motivated?**

Use 1-6 scale: 1=Highly motivated 6= No motivation

☐1 ☐2 ☐3 ☐4 ☐5 ☐6

ANXIETY, DEPRESSION SCREENING (PHQ-4)

Over the last 2 weeks, how often have you been bothered by the following?
USE SCALE 0-3
0 = not at all, several days =1, more than 50% = 2, almost every day = 3

1. **Feeling nervous, anxious or on edge?**

☐ 0 ☐1 ☐ 2 ☐ 3

2. **Not being able to stop or control worrying?**

☐ 0 ☐1 ☐ 2 ☐ 3

3. **Little interest or pleasure in doing things**

☐ 0 ☐1 ☐ 2 ☐ 3

4. **Feeling down, depressed, or hopeless**

☐ 0 ☐1 ☐ 2 ☐ 3

TMD PAIN RELATED DISABILITY – measured by the Graded Chronic Pain Scale (GCPS)

High pain-related disability can be common. On a scale of 1-10 (0 = no change; 10= extreme change) how much has pain changed your ability to? Please circle

A) Take part in recreational, social and family activities

0 1 2 3 4 5 6 7 8 9 10

B) Work

0 1 2 3 4 5 6 7 8 9 10

C) How many days in the past 6 months has pain kept you from your usual activities?

_____

PERCEIVED STRESS SCALE:

Please circle the numbers below to indicate your thoughts and feelings during the last month in relation to each question.

0= never 1 = almost never 2= sometimes 3= quite often 4= very often

1. In the last month, how often have you been upset because of something that had happened unexpectedly

   0 1 2 3 4

2. In the last month, how often have you felt that you were unable to control the important things in your life?

   0 1 2 3 4

3. In the last month, how often have you felt nervous and stressed?

   0 1 2 3 4

4. In the last month, how often have you felt confident about your ability to handle your personal problems?

   0 1 2 3 4

5. In the last month, how often have you felt that things were going your way?

   0 1 2 3 4

6. In the last month, how often have you found that you could not cope with all the things that you had to do?

   0 1 2 3 4

7. In the last month, how often have you been able to control irritations in your life?

   0 1 2 3 4

8. In the last month, how often have you felt that you were on top of things?

   0 1 2 3 4

9. In the last month, how often have you been angered because of things that were outside of your control?

   0 1 2 3 4

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

    0 1 2 3 4

PAIN CATASTROPHIZING SCALE:

Everyone experiences painful situations at some point in their lives, such as headaches, tooth pain, joint or muscle pain. Please indicate the degree to which you have these thoughts/ feelings when you're in pain.

0= not at all 1 = to a slight degree 2= to a moderate degree 3= to a great degree 4= all the time

1. It is terrible and I think it is never going to get any better

   0 1 2 3 4

2. I feel I can't stand it anymore

   0 1 2 3 4

MIGRAINE QUESTIONNAIRE:

Please fill out the below questionnaire if you suffer from migraine/tension headaches.

How does the headache/migraine start?

Do you have an aura?

How long does the migraine/headache last?

How many days in the last month have you had any sort of headache?

Does it restrict activities?

Is there any particular trigger?

Briefly describe the location:

Please outline your treatment - if you utilise medication, what protocol do you follow?

MEDICAL HISTORY: *Mark the box in the appropriate column indicating whether or not you presently have, had in the past, or never had any of the following conditions or symptoms.*

PERSONAL HISTORY NEVER	PAST	PRESENT		FAMILY HISTORY YES
☐	☐	☐	Asthma	☐
☐	☐	☐	Cancer	☐
☐	☐	☐	Candidiasis	☐
☐	☐	☐	Childhood diseases (Measles, Chickenpox, etc,)	☐
☐	☐	☐	Contracted AIDS	☐
☐	☐	☐	Contracted Hepatitis A☐ B☐ C☐	☐
☐	☐	☐	Contracted Herpes	☐
☐	☐	☐	Diabetes	☐
☐	☐	☐	Endocrine or hormonal problems	☐
☐	☐	☐	Exposed to AIDS	☐
☐	☐	☐	Exposed to Hepatitis A☐ B☐ C☐	☐
☐	☐	☐	Fainting spells or feeling faint	☐
☐	☐	☐	Fibromyalgia/Rheumatoid Arthritis/Lupus or any Autoimmune Diseases	☐
☐	☐	☐	Frequent exhaustion or fatigue	☐
☐	☐	☐	Frequently irritable	☐
☐	☐	☐	Hands get cold	☐
☐	☐	☐	Heart disease	☐
☐	☐	☐	Heartburn / Gastric Reflux	☐
☐	☐	☐	High blood pressure (Hypertension)	☐
☐	☐	☐	High ☐ or Low ☐ blood sugar	☐
☐	☐	☐	Low blood pressure (Hypotension)	☐
☐	☐	☐	Muscle soreness or stiffness	☐
☐	☐	☐	Osteoarthritis (neck, joints, etc.)	☐
☐	☐	☐	Tightness in chest	☐
☐	☐	☐	Slow healing sores	☐
☐	☐	☐	Swollen, stiff or painful joints	☐
☐	☐	☐	Thyroid Disease	☐
☐	☐	☐	Others? *Please explain below:*	☐
☐	☐	☐	Others? *Please explain below:*	☐

_____

_____

☐ ☐ Any surgeries? *Please note:*

_____

_____

_____

MEDICINES: *Please list all medications currently being taken:*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please list ALL medications you are allergic to:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Please list ALL allergies:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

PREVIOUS TREATMENT: *Since your problem(s) began, which of the following have you seen or are presently seeing for your treatment and relief of pain?*

PRESENT	PAST		NAME OF DOCTOR
☐	☐	Acupuncturist	_____
☐	☐	Allergist	_____
☐	☐	Anaesthesiologist	_____
☐	☐	Cardiologist	_____
☐	☐	Chiropractor	_____
☐	☐	Dentist	_____
☐	☐	Dermatologist	_____
☐	☐	Ear, Nose and Throat	_____
☐	☐	Endocrinologist	_____
☐	☐	Endodontist	_____
☐	☐	GP	_____
☐	☐	Gynaecologist/Obstetrician	_____
☐	☐	Internist	_____
☐	☐	Neurologist	_____
☐	☐	Neurosurgeon	_____
☐	☐	Ophthalmologist	_____
☐	☐	Optometrist	_____
☐	☐	Oral Surgeon	_____
☐	☐	Orthopaedist	_____
☐	☐	Orthodontist	_____
☐	☐	Osteopathic Physician	_____
☐	☐	Pain Specialist	_____
☐	☐	Paediatrician	_____
☐	☐	Periodontist	_____
☐	☐	Physical Therapist (Physio)	_____
☐	☐	Plastic Surgeon	_____
☐	☐	Psychiatrist	_____
☐	☐	Psychologist	_____
☐	☐	Radiologist	_____
☐	☐	Rheumatologist	_____
☐	☐	Sleep Specialist	_____
☐	☐	Other:	_____
☐	☐	Other:	_____

MEDICAL TESTS: *Please Indicate whether or not you have had any of the following diagnostic tests during the* ***past 2 years.***

YES	NO	
☐	☐	Allergy Testing _____
☐	☐	Arthritis Tests _____
☐	☐	Blood Tests _____
☐	☐	Muscle Tests _____
☐	☐	Neurological Tests _____
☐	☐	Urine Tests _____
☐	☐	X-rays _____
☐	☐	CAT Scan _____
☐	☐	MRI _____
☐	☐	Arthrogram _____
☐	☐	Bone Scan _____
☐	☐	Other _____

LIFESTYLE HABIT PATTERNS:

YES NO

1. □ □ Do you sleep well?

2. Do you sleep…
   - □ □ On your back?
   - □ □ On your side?
   - □ □ On your stomach?
   - □ □ With a pillow?
   - □ □ With hand or arm under head?
3. □ □ Do you exercise regularly?
4. □ □ Are you a singer?
5. What instruments do you play? _____

6. Do you usually eat…
   - □ □ Breakfast?
   - □ □ Lunch?
   - □ □ Dinner?
   - □ □ Between meals?
   - □ □ Before bed?
7. □ □ Is your diet medically supervised?

8. Do you regularly consume any of the following?
   - □ □ Dairy products?
   - □ □ Chocolate?
   - □ □ Sweets?
   - □ □ Natural coffee? ____Cups/day
   - □ □ Decaf coffee? ____Cups/day
   - □ □ Natural tea? ____Cups/day
   - □ □ Decaf tea? ____Cups/day
   - □ □ Fruit juice? ____Cups/day
   - □ □ Water? ____Cups/day
   - □ □ Alcoholic beverage? ____Drinks/Cans/day
   - □ □ Soft drink? □Diet? □Reg? ____Bottles/Cans/day
   - □ □ Other? ____Bottles/Cans/day
   - □ □ Tobacco? □ Smokeless? □ Smoker? ____#/day

9. Please list any vitamins, minerals, supplements or herbals you regularly take. Specify amount (number of mg per day):
   _____
   _____
   _____
   _____
   _____

10. Work Habits:
    Occupation_____
    Duties: _____
    _____
    Sit _____ Stand_____

11. Please note your hobbies, sports, recreation activities:
    _____
    _____

12. Do you sleep with your Mobile devices within 3 metres of your bed at night?
    □Yes □No

13. Do you have Wi-Fi internet connections on in your home? □Yes □No

    Do you have it on during sleep hours? □Yes □No

14. Do you watch Blue screen devices (TV, tablets, mobiles etc.) 1 hour before bedtime?
    □Yes □No

BREATHING AND SLEEP:

YES NO

1. □ □ Do you have difficulty falling asleep?
   a. How many times each night do you wake up? _____
   b. How many hours do you sleep each night? _____

2. □ □ Is your sleep interrupted because of a need to urinate? If so, how many times during night? _____

3. □ □ Do you often awaken feeling refreshed?

4. □ □ Does pain interfere with your sleep?

5. □ □ Do you wake up with a headache? If so, how often and what time? _____

6. □ □ Do you have difficulty breathing through your nose?

7. What is your normal bedtime? _____

8. What is your normal wake up time? _____

9. □ □ Does your work schedule change??

10. □ □ Do you have any memory loss?

11. □ □ Have you had a sleep study?
    When? _____ Where? _____

12. □ □ Have you had surgery for airway improvement?

13. □ □ Do you use a CPAP type machine? If so, for how long? ____

14. □ □ Have you used an oral appliance for sleep apnoea or snoring? Other treatment?
    _____

SLEEP SYMPTOMS:

1. **Performance Ability:**
   During the past month, how would you rate your ability to perform tasks at home and at work?
   Use 1-6 scale: 1=Best: Alert, Concentrate Well 6=Worse: Feel foggy, tired
   □1 □2 □3 □4 □5 □6

2. **Interference with Daily Tasks:**
   During the last month, to what extent has sleepiness interfered with your life?
   Use 1-6 scale: 1=No interference 6=Totally
   □1 □2 □3 □4 □5 □6

3. **Energy Level:**
   During the last month, how would you rate your level of energy?
   Use 1-6 scale: 1=Fresh as a daisy 6=Tired to death
   □1 □2 □3 □4 □5 □6

Sleep Symptoms continued…

Fallen-asleep Driving:

Have you ever fallen asleep while you were behind the wheel of a motor vehicle? ☐Yes ☐No ☐Don't know

If answer is Yes, has it occurred…

☐Once ☐2-5 times ☐6-20 times

☐21-100 times ☐over 100 times ☐Do not know

SLEEP QUESTIONNAIRE:

Epworth Sleepiness Scale

In contrast to feeling tired, are you likely to doze or fall asleep in the following situations?

Please mark your response and total

0=Never 1=Slight chance 2=Moderate Chance 3=Regularly

Sitting quietly after lunch with no alcohol?	0	1	2	3
In a car while stopped for a few minutes in traffic?	0	1	2	3
Sitting inactive in a public place? (e.g. Movies?)	0	1	2	3
Passenger in a car for an hour without a break?	0	1	2	3
Sitting and reading?	0	1	2	3
Watching television?	0	1	2	3
Lying down to rest in the afternoon?	0	1	2	3
Sitting and talking to someone?	0	1	2	3

TOTAL ALL OF THE NUMBERS MARKED: _____

Please mark any of your symptoms and how often they occur.

0=Never 1=Rarely 2=Some of the Time 3=Frequently 4= Most of the Time

Apnoea/Snoring

I have been told that I snore loudly even when I am sleeping on my side	0	1	2	3
My snoring disturbs other people	0	1	2	3
I have been told that I snore when sleeping on my back	0	1	2	3
I am hoarse in the morning when I wake	0	1	2	3
I have been told that "I stop breathing" when sleeping	0	1	2	3
I wake up in the morning with headaches	0	1	2	3
I notice swelling or puffiness in my ankles or feet at night	0	1	2	3
I sweat at night when sleeping, without being hot	0	1	2	3

TOTAL ALL OF THE NUMBERS MARKED: _____

Other Sleep Behaviour

I kick or twitch my legs at night prior to falling asleep	0	1	2	3
I have aching or "crawling" sensations at night	0	1	2	3
I have been told I kick or twitch my legs when asleep	0	1	2	3
I have been told that I grind or clench my teeth while sleeping	0	1	2	3
I wake at night and cannot go back to sleep	0	1	2	3
I walk or talk in my sleep	0	1	2	3

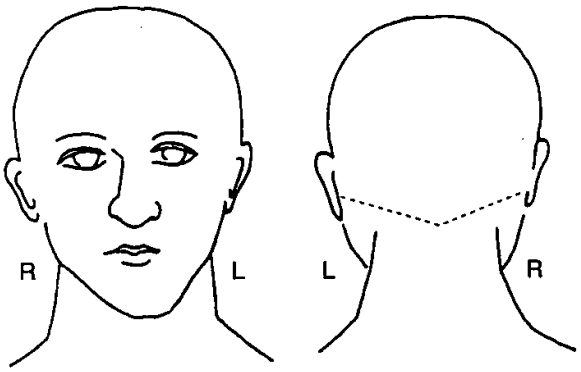
TOTAL ALL OF THE NUMBERS MARKED: _____

Narcolepsy

When angry or surprised, I feel like I am going to "blackout"	0	1	2	3
I experience vivid, life like scenes when I am very tired	0	1	2	3
I awaken and cannot move, feeling like I am paralysed	0	1	2	3

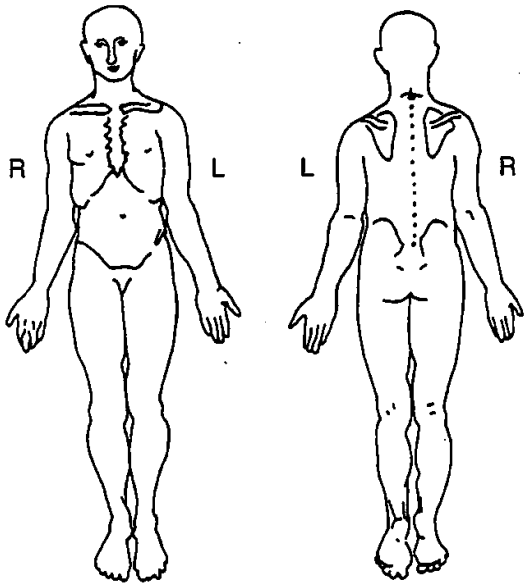
TOTAL ALL OF THE NUMBERS MARKED: _____

Please mark on the drawings below by using the *PAIN PATTERN KEY.* Mark where your pain concerns are and what type of pain it is.

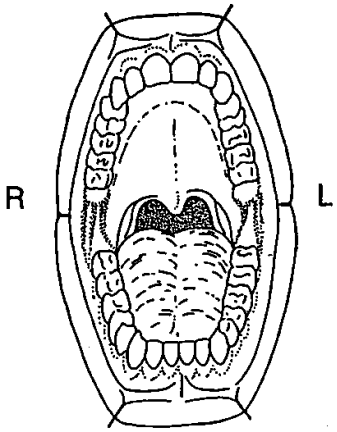


PAIN PATTERN KEY:

Numbness	B Burning
Pain	D Dull
Moderate Pain	H Heavy Pressure
Severe Pain	S Sharp
Direction of Pain	T Tingling
	R Radiating



MOUTH



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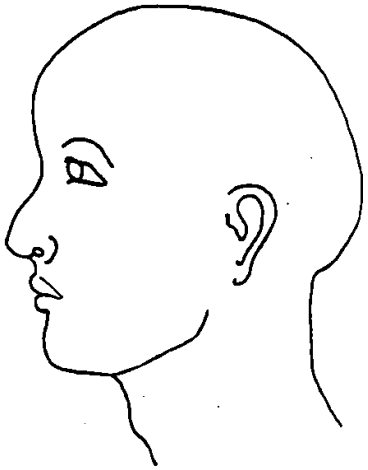

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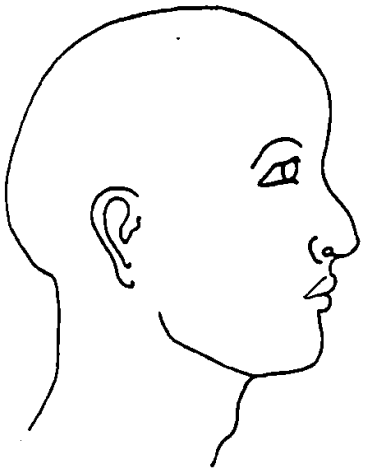

Craniofacial Pain and Orthopostural Dentistry

Chronic pain of the head and neck regions is often a symptom related to TMJ syndrome. The TMJ, or temporomandibular joint, attaches the mandible (lower jaw) to the skull. Jaw movement is controlled by a complex balance of several muscles and ligaments. Many of these muscles also attach to the neck and shoulders and are important in stabilising the head (think of a 6-7kg bowling ball) on the cervical spine or neck. Acute whiplash-type injuries or chronic conditions such as a bad bite or aberrant breathing and swallowing habits all result in postural compensation of the head and neck, causing these stabilising muscles to be constantly activated.

Coincident with muscular protection systems is a neurological alarm called the autonomic nervous system (the ANS). The ANS protects the body by turning on or off all the involuntary services the body requires to maintain 'homeostasis' or balance. This includes blood pressure, blood sugar levels, breathing rate and muscle activity. When this system is constantly in alarm mode its ability to maintain homeostasis is compromised, leading to pain and other systemic medical conditions.

To successfully and efficiently treat craniofacial pain it is important to realise that the ANS has a priority alarm program and in diagnosis it is essential that priority is established and treatment is sequential. There is no higher priority for the body than to breathe. We can survive days without food or water but only minutes without breathing – our bodies will thus prioritise the breathing system, and will often compromise other systems in order to support respiratory function. One of the fundamental drivers underlying the pathophysiology of chronic pain due to postural adaptation is the struggle to maintain a patent airway. Our observations have indicated that nasal breathing and optimal breathing habits are an essential treatment priority in attempting to alleviate and maintain homeostasis, autonomic balance and postural alignment.

Orthopostural dentistry involves an initial focus on stabilising or balancing the head on the cervical spine. Studies show that 94% of head posture compensation is a result of jaw joint dysfunction. Jaw stabilisation is achieved using acrylic molar splints at night. For many patients this restoration of structural balance is all that is required for pain to be alleviated and the stomatognathic system to be returned to normal function. For patients in a more 'compensated' or denatured state, more complex treatment may be required, such as further structural (cranial) release; a focus on biochemical factors; associated evaluation of emotional input; and other allied modalities. Experience has demonstrated to us that it is important to treat each of these further compensations in priority – much like peeling an onion – and a systematic, closely monitored approach is required.

At the conclusion of Phase I treatment the patient may continue to use stabilising splints and other adjunctive treatment mechanisms to maintain a pain free state or, now that stability has been achieved, embark upon Phase II structural correction treatment as recommended. This may include mandibular advancement splints to position the lower jaw in a more ideal posture when sleeping, or more advanced definitive orthopaedic, orthodontic or restorative techniques.

Stabilising splints

Internal derangement involves actual pathology of the temporomandibular joint mechanism. This may involve inflammatory conditions retrodiscitis, capsulitis or subluxation of the disc (clicking, popping) or locking of the joint (limited opening and lateral movements).

The most common cause of this condition is prolonged loading of the joint mechanism. This may be as a result of certain malocclusions, poor tooth alignment or gradual collapse of the supporting molar teeth.

Treatment requires unloading of the joint mechanism to allow healing and resolution of the inflammatory conditions. This is achieved by the use of a stabilising splint and may take up to **six months of treatment.**

This appliance needs only to be worn at night. As resolution occurs, pain and/or limitation should decrease and the appliance may become unbalanced, thereby requiring adjustment.

DO NOT PLACE STABILISING SPLINT APPLIANCES IN HOT WATER!

Treatment Outline

Initial diagnostic

Consultation	011,963	
Diagnostic Models, creation of study models	071x2	
Radiographic tracing and model analysis	081, 082	
OPG and Lateral Ceph Radiographs	036, 037	**$395**
Respiratory/Myofunctional assessment		
ResMed Apnoea Link take home sleep study device (if required) -		
Including an appointment to assess results		**$150**
Follow up sleep studies/result assessment		**$80**

INFORMED CONSENT

PATIENT NAME:_____

A proper diagnosis regarding head and neck pain and TMJ disorders is fundamental to treatment as more serious medical problems such as vascular disorder; brain tumours and cervical disc disorders can produce symptoms similar to TMJ disorders. It is therefore important to inform our surgery when any changes in your personal health history occur.

Length of treatment may vary according to the complexity of your condition. Although most conditions respond well to treatment, general health, stress, degree of tissue injury, posture, age, work habits and bite relationship do affect the outcome, and total resolution is not always possible. The treatment methods we will use are based on research, profession studies and our experience and knowledge. These methods have proven to be the most appropriate, cost effective and conservative. However, you should be aware that there is much debate in the medical-dental community regarding the best way to treat various TMJ disorders.

Good communication is essential to successful treatment. Please feel free to discuss any questions you may have regarding your treatment. Referrals to other professionals such as chiropractors, osteopaths, physiotherapists, nutritionists, oral surgeons, orthodontists, medical doctors, neurologists, or ear, nose and throat specialists may be indicated and necessary for successful treatment.

I acknowledge that the treating dentist is neither an orthodontist nor an oral surgeon but rather a dentist who has undertaken numerous post graduate courses in sleep medicine, orthopaedics and TMD (Temporomandibular Dysfunction) and has completed his Masters in Orofacial Pain Management.

I acknowledge that I have read and understand the costs for splint appliances and hereby record my acceptance of such as an estimated cost for the initial phase of any associated treatment.

As with any medical or dental treatment the success depends to a large extent on the degree of cooperation of the patient in following the prescribed treatment plan. This includes wearing the appliance/s as directed and following exercise outlines and/or appropriate referrals. Failure to comply with instructions could delay the treatment time and seriously affect the success of the treatment.

No orthodontic appliance should be used without regular evaluations at this surgery.

Signed _____
Date_____