

TM/AIRWAY-SLEEP SCREENING Form

PATIENT NAME: _____ DATE: _____

1. Have you ever been told that you need to wear CPAP for sleep? Yes No
2. Do you use over the counter medication for headache pain or as a sleeping aid? Yes No
3. Is it easy for you to get to sleep? Yes No Do you wake often? Yes No
4. Do you feel rested when you wake in the am? Yes No
5. Do you experience sounds like popping or clicking in the jaw joints? Yes No

Patient Signature: _____

Date: _____

FOR CLINICAL OFFICE USE:

JVA QUICK Completed Yes No

Range Of Motion Measurements:

Interincisal Opening (w/o pain) _____ mm

Interincisal Opening (with pain) _____ mm

Lateral Excursion Right _____ mm

Lateral Excursion Left _____ mm

Protrusive _____ mm

By: _____ (Initials)

Date: _____