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 morning? *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* ☐ BP: _____ Openbite: _____

OB: _____mm OJ: _____mm

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**: _____