Cranial History

Name:_____ Sex:____ Age:_____ Date:_____

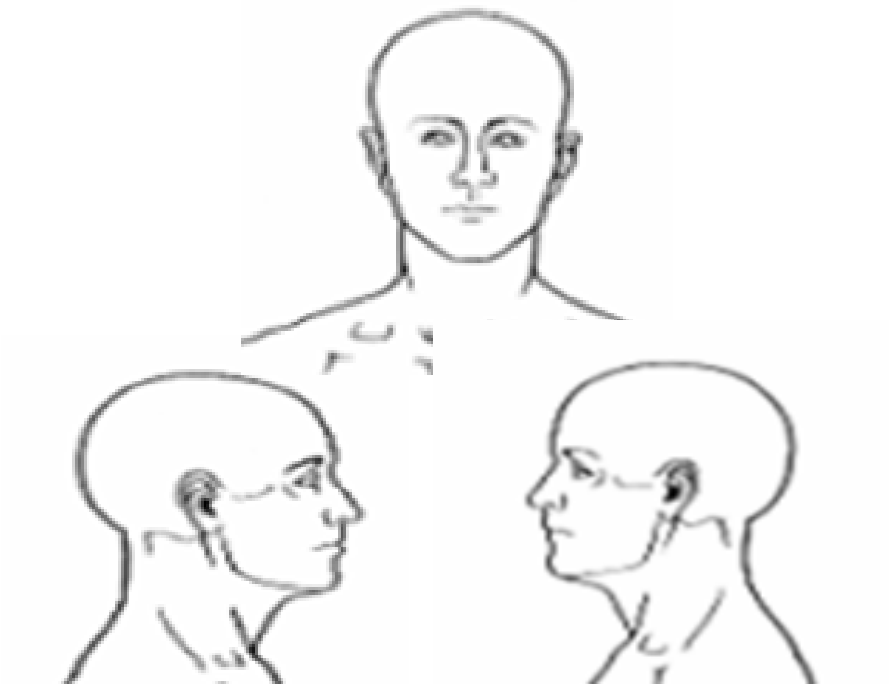
Address:_____

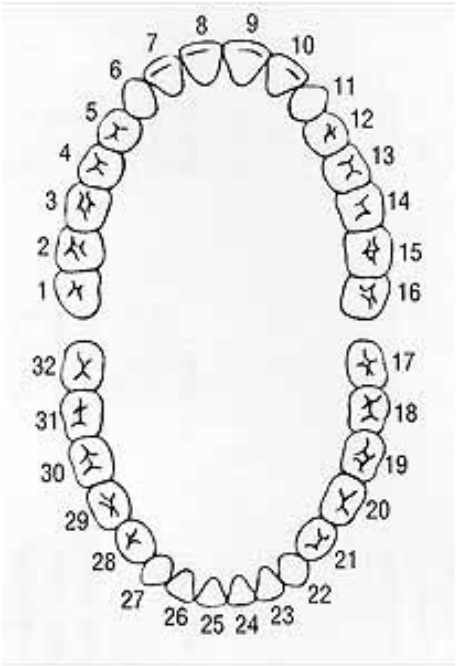
City:_____ State:_____ Zip:_____

Phone #:_____ Referred by:_____

How did you hear about us? ❒ Internet ❒ Person Other _____

Please mark the region of your concern on the diagrams below.





Please describe any specific concerns:

❒ Dental _____

❒ Sinuses _____

❒ Facial Pain or Numbing _____

❒ Thyroid Concerns_____

❒ Lumps in Neck_____

❒ Dizziness or Lightheadedness_____

❒ Other _____

Do you have any history of:

❒ Stroke ❒ Cardiovascular Disease ❒ Dizziness ❒ Fainting

Please Describe: _____

❒ Past Injuries to the face

Please Describe: _____

Do you have any diagnosed diseases?

Please Describe: _____

Do you have any past surgeries to the head, face or mouth?

Please Describe: _____