## Patient Health Questionnaire

### Patient Information

- **Date of completion**: 

  - **Mr.**, **Ms.**, **Miss**, **Mrs.**, **Dr.**

- **Name**: 

- **Age**: 

- **Date of Birth**: 

- **Referred by**: 

- **Location and/or Phone Number of Healthcare Provider**: 

- **Patient Address**: 

- **Home Phone**: 

- **Alternate Contact Number**: 

- **Type of Employment**: 

- **Responsible Party (if different than Patient)**: 

- **Address**: 

- **City**: 

- **State**: 

- **Zip**: 

- **Family Dentist**: 

- **Address and/or Phone**: 

- **Family Physician**: 

- **Address and/or Phone**: 

- **Reason(s) for this appointment**: 
  - [ ] Pain
  - [ ] Sleep/Airway
  - [ ] Orthodontics
  - [ ] Unknown

### What is the Chief Complaint for Which You Are Seeking Treatment in Our Office?

**Note**: Please identify your chief complaint as #1, list all other symptoms in priority #2-9.

<table>
<thead>
<tr>
<th>Complaint</th>
<th>Recent</th>
<th>Chronic (6 mo.)</th>
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<tbody>
<tr>
<td>Headache pain</td>
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<tr>
<td>Ear pain</td>
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<tr>
<td>Jaw pain</td>
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<td>Pain when chewing</td>
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<td>Facial pain</td>
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<tr>
<td>Eye pain</td>
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<td>Throat pain</td>
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<tr>
<td>Neck pain</td>
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<tr>
<td>Shoulder pain</td>
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<td>Back pain</td>
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<tr>
<td>Limited ability to open mouth</td>
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<tr>
<td>Jaw joint locking</td>
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<td>Jaw joint noises</td>
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<td>Ear congestion</td>
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<td>Sinus congestion</td>
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<tr>
<td>Dizziness</td>
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<td>Tinnitus (ringing in the ears)</td>
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<td>Muscle twitching</td>
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<tr>
<td>Vision problems</td>
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</tbody>
</table>

| Other: | | |

Do you have concerns in any of these areas? 

- [ ] General Appearance
- [ ] Overbite
- [ ] Ability to Function
- [ ] Smile

**Other Comments**: 

Write your comments here.

Do any of the above complaints or concerns affect your daily life? 

**What are the Results You Are Seeking from Treatment?** 

**Patient Signature**: 

**Date**: 

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ALLERGIC REACTIONS

Please check any and all medications or substances that have caused an allergic reaction

☐ Anesthetics
☐ Antibiotics
☐ Aspirin
☐ Barbiturates
☐ Codeine
☐ Iodine
☐ Latex
☐ Metals
☐ Penicillin
☐ Plastic
☐ Sedatives
☐ Sulfa

Other: ____________________________

CURRENT MEDICATIONS

Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs, etc.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Reason for Taking</th>
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</tbody>
</table>

☐ See attached list

PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

<table>
<thead>
<tr>
<th>Treatment and/or Medication</th>
<th>Doctor/Provider Name</th>
<th>Approximate Date of Treatment</th>
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</thead>
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</tbody>
</table>

I release and give my permission for this office to request information and communicate with the providers listed above.

Patient Signature: ____________________________  Date: ____________________________

Parent/Guardian Signature (if patient is a minor): ____________________________  Date: ____________________________

HEALTH AND MEDICAL HISTORY

☐ Yes ☐ No  Are you currently pregnant?

☐ Yes ☐ No  Have you sustained injury to:  ☐ Head  ☐ Neck  ☐ Face  ☐ Teeth  ☐ Other: ____________________________

☐ Yes ☐ No  Do you drink 4 or more cups of coffee per day?

☐ Yes ☐ No  Do you smoke tobacco?

☐ Yes ☐ No  Have you had prior orthodontic treatments?

☐ Yes ☐ No  Consume alcohol or take sedatives (for pain relief or sleeping)

☐ Yes ☐ No  Trouble breathing through nose

Patient Signature: ____________________________  Date: ____________________________

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**HEALTH AND MEDICAL HISTORY (CONTINUED)**

*Do you have, or have you experienced any of the following:*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disorder/ Heart Attack</td>
<td>Thyroid Problem</td>
</tr>
<tr>
<td>Heart Murmur</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Mitral Valve Prolapse</td>
<td>Intestinal Disorder</td>
</tr>
<tr>
<td>Heart Pacemaker</td>
<td>Nervous System Disorder</td>
</tr>
<tr>
<td>Heart Palpitations</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Heart Valve Replacement</td>
<td>Skin Disorder</td>
</tr>
<tr>
<td>Irregular Heartbeat</td>
<td>Urinary Tract Disorder</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Chronic Fatigue</td>
</tr>
<tr>
<td>Stroke</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>Bleeding Easily</td>
<td>Cold hands and feet</td>
</tr>
<tr>
<td>Bruising Easily</td>
<td>Depression</td>
</tr>
<tr>
<td>Cancer of</td>
<td>Difficulty concentrating</td>
</tr>
<tr>
<td>Chemo</td>
<td>Difficulty breathing at night for sleep</td>
</tr>
<tr>
<td>Radiation</td>
<td>Dizziness</td>
</tr>
<tr>
<td>Anemia</td>
<td>Excessive Thirst</td>
</tr>
<tr>
<td>Asthma</td>
<td>Fainting</td>
</tr>
<tr>
<td>Birth Defects</td>
<td>Fluid Retention</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Frequent colds/flu</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Frequent cough</td>
</tr>
<tr>
<td>Emphysema</td>
<td>Frequent ear infections</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Frequent sore throat</td>
</tr>
<tr>
<td>Gastroesophageal Reflux (GERD)</td>
<td>Frequent waking at night - number of times</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>Hearing impairment</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>Memory Loss</td>
</tr>
<tr>
<td>History of Substance Abuse</td>
<td>Hay Fever</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Huntington's Disease</td>
<td>Muscle aches</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>Muscle fatigue</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>Muscle spasms</td>
</tr>
<tr>
<td>Leukemia</td>
<td>Muscle tremors</td>
</tr>
<tr>
<td>Migraines</td>
<td>Poor circulation</td>
</tr>
<tr>
<td>Meniere's Disease</td>
<td>Psychiatric Care</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>Recent weight gain</td>
</tr>
<tr>
<td>Muscular Dystrophy</td>
<td>Recent weight loss</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>Sinus problems</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Slow healing sores</td>
</tr>
<tr>
<td>Ovarian Cyst</td>
<td>Speech difficulties</td>
</tr>
<tr>
<td>Parkinson's Disease</td>
<td>Swollen, stiff or painful joints</td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td>Tired muscles</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>Other</td>
</tr>
</tbody>
</table>

**SURGICAL HISTORY**  *Have you had any of the following:*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Anesthesia</td>
<td>Orthognathic Surgery</td>
</tr>
<tr>
<td>Adenoids removed</td>
<td>Oral Surgery</td>
</tr>
<tr>
<td>Tonsils removed</td>
<td>Removal of third molar (wisdom teeth)</td>
</tr>
<tr>
<td>Jaw Joint Surgery</td>
<td>Other surgery</td>
</tr>
</tbody>
</table>

**Other types of surgery**

__please list below__

**Patient Signature:** ____________________________  **Date:** ____________________________

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**CURRENT SYMPTOMS**

**Head Pain**

<table>
<thead>
<tr>
<th>Location</th>
<th>Recent</th>
<th>Chronic (over 6 mo.)</th>
<th>Severity</th>
<th>Duration</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>L. Frontal (Forehead)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>L. Generalized</td>
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<tr>
<td>L. Parietal (Top of head)</td>
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<tr>
<td>L. Occipital (Back of head)</td>
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<tr>
<td>L. Temporal (Temple area)</td>
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</tbody>
</table>

Do you have pain or discomfort in any of the following areas? If so, please indicate the approximate date the pain began.

**Jaw Pain**

- L. Jaw pain with opening
- L. Jaw pain when chewing
- L. Jaw pain at rest

**Jaw Joint Sounds**

- L. Jaw sounds with opening
- L. Jaw sounds when chewing
- L. Jaw sounds at rest

**Jaw Locking**

- Yes: Jaw locks closed
- Yes: Jaw locks open

**Eye Related Conditions**

- Yes: Blurred vision
- Yes: Double vision
- Yes: Eye pain

**Jaw Joint Symptoms**

- Yes: Teeth clenching
- Yes: Teeth grinding

**Ear Related Conditions**

- L. Buzzing in the ears
- L. Ear congestion
- L. Ear pain
- L. Hearing loss
- L. Itchiness or Stiffness in ears

**Throat Related Conditions**

- Yes: Chronic sore throat
- Yes: Difficulty swallowing
- Yes: Swollen glands

**Neck Related Conditions**

- Yes: Limited movement of neck
- Yes: Neck pain

- Yes: Numbness in hands or fingers
- Yes: Swelling in the neck

Patient Signature: ___________________________  Date: ________________
Shoulder Related Conditions
- Yes ☐ No ☐ Shoulder pain
- Yes ☐ No ☐ Shoulder stiffness

Back Related Conditions
- Yes ☐ No ☐ Back pain - lower
- Yes ☐ No ☐ Back pain - middle
- Yes ☐ No ☐ Back pain - upper
- Yes ☐ No ☐ Sciatica
- Yes ☐ No ☐ Scoliosis

Mouth and Nose Related Conditions
- Yes ☐ No ☐ Dry mouth
- Yes ☐ No ☐ Chronic sinusitis
- Yes ☐ No ☐ Frequent snoring
- Yes ☐ No ☐ Burning tongue
- Yes ☐ No ☐ Broken teeth
- Yes ☐ No ☐ Frequent biting of the cheek

Sleep Conditions
- Side ☐ Back ☐ Stomach ☐ Varies
- Is it easy to fall asleep? Yes ☐ No
- Do you feel rested upon AM waking? Yes ☐ No
- Stopped breathing during sleep? Yes ☐ No

Average hours of sleep per night? __________________________
Do you wake often during the night? Yes ☐ No
Gasping or Choking during sleep? Yes ☐ No
Have you ever had a Sleep Study (PSG)? Yes ☐ No
Result was __________________________

HISTORY OF SYMPTOMS
On what date, or approximate date, did this condition or symptoms first occur? __________________________

Yes ☐ No Does any family member have the same or similar problem? If yes, please explain. __________________________

Can you relate your pain or condition to a motor vehicle accident or traumatic injury? __________________________
If yes, please complete Trauma History Section, enclosed as a separate form.

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient Signature: __________________________ Date: __________________________

Parent/Guardian Signature (if patient is a minor): __________________________ Date: __________________________
Indicate Areas of Pain
Following the Pain Scale:
1  Mild pain
2  Moderate pain
3  Severe pain
HEADACHE QUESTIONNAIRE

1. How long have you been having headaches? Please be specific in terms of months and years ____________________________________________

2. What time of day (or night) do you feel the pain? (Mornings, toward the end of the day, mid to late evening, all day long, needs to be triggered, combination of above, etc.) Please be specific ____________________________________________

3. What side of the head does the pain usually occur? On one side only, or both sides? Front and/or back of your head? Does it alternate? ____________________________________________

4. How often does the pain occur? (Once or more a week, once a month, etc. Please be specific.) ____________________________________________

5. How long does the pain last? (Minutes, hours, or days? Please be specific.) ____________________________________________

6. Where does the pain begin? Is this a repeated location(s)? ____________________________________________

7. Does the pain move around your head? Does it start one place then move? Please be specific ____________________________________________

8. Is the pain deep to the touch, or is it near the surface of the skin? ____________________________________________

9. On a scale of 1 to 10, where one is not noticeable pain and ten being the most intense pain, how would you rate your headache pain? ____________________________________________

10. How often does it get to that intensity? ____________________________________________

11. What type of pain is it? (dull ache, sharp stabbing, boring, numbness, emptiness, tight band around the head, pressure, tingling, intense) ____________________________________________

12. Do you experience altered vision or difficulty seeing related to the headache? ____________________________________________

13. Do you experience bloating, gas, constipation or diarrhea after meals? ____________________________________________

14. What can bring on a headache?: certain foods, alcohol, caffeine, tiredness, menstrual cycle, emotional upset, physical activity, poor sleep, elevation change, or pain in other parts of the body. ____________________________________________

15. What can decrease the pain? Sleep, rest, foods, exercise, menstrual cycle, vomiting, caffeine, medication, or healthy conversation. ____________________________________________

16. Are there any other parts of your body that also hurt? (Neck, back, jaw, etc.) Please be specific ____________________________________________

17. What else do you notice when you have the pain? (Ringing in the ears, dizziness, loss of balance, jaw noises, sensitivity to: light, sounds or smells, pain in other parts of the body, nausea/vomiting). ____________________________________________

18. Please list previous treatments you have had for this condition? Which, if any, have helped? ____________________________________________

19. What is currently being done to treat the headaches? ____________________________________________

20. Is it related in any way to a life event, accident, trauma or dental experience? ____________________________________________

21. What do you think is the cause of the pain? ____________________________________________

22. Are there family members with Headaches? Who? ____________________________________________

23. What brings you to treatment at this time? ____________________________________________
AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW
LISTED REFERRING AND TREATING HEALTH CARE
PROFESSIONALS:

<table>
<thead>
<tr>
<th>Doctors Name</th>
<th>Location/Phone</th>
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I authorize the release of communications regarding my treatment with
__________________________________________ including a full report of examination
findings, diagnosis, treatment plan, and progress reports to the providers
listed above.

Signed __________________________ Date ____________
SLEEP QUESTIONNAIRE

Please complete all information to aid your Doctor in evaluating your Sleep.

Last Name_________________________________________First Name___________________________M.I._______
D.O.B.______
Age____ Height____ Weight__________
Gender M/F Smoker Y/N Alcohol Y/N Recreational Drugs Y/N Prescription Drugs Y/N
Referring Doctor _________________________________ Phone Number (_____)__________________
Address_________________________________ City____________________ State_____ ZIP__________

Please answer the following questions as it relates to your sleeping patterns.
1) How long does it take for you to fall asleep?________(minutes)
2) How many times do you awaken at night?____________(# of times)
3) How long does it take you to fall back asleep?________(minutes)
4) What wakes you? (pain, bathroom, thoughts racing in mind, gasping, etc.)_________________________
5) Do you take nap(s) in the day time?________
6) Do you ever need a sleeping aid to get to sleep?__________ (Sleeping pill, music, alcohol, etc)
7) If so, what, how much, and how often? _____________________________________________________
8) Do you prefer to have noise or light on in the evening (i.e TV, etc) __________
9) Of the time spent in your bed, what proportion do you estimate you spend on your:
back_______ side_______ stomach_______ (Be sure that these total 100% please).

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation Chance of Dozing
Sitting and Reading.............................................................................................................._
Watching TV......................................................................................................................_
Sitting inactive in a public place (e.g. a theater or a meeting) ........................................._
As a passenger in a car for an hour without a break......................................................_
Lying down to rest in the afternoon when circumstances permit....................................._
Sitting and talking to someone ........................................................................................_
Sitting quietly after lunch without alcohol........................................................................_
In a car, while stopped for a few minutes in traffic........................................................_

Total score ..........
1. I have been told that I snore.
2. I have been told that I hold my breath when I sleep.
3. I have high blood pressure/Hypertension.
4. My friends and family say that I’m grumpy and irritable.
4A. I have depression and/or anxiety.
5. I wish I had more energy.
6. I sweat excessively during the night.
7. I have noticed my heart pounding or beating irregularly during the night.
8. I get morning headaches
8A. I have migraines.
8B I have a Jaw problem (pain, clicking).
9. I suddenly wake gasping for breath.
10. I am overweight more than 10lbs.
10A. I have to drink several cups of coffee or tea to stay alert throughout the day.
11. I seem to be losing my sex drive.
12. I often feel sleepy and struggle to remain alert.
12A. I have noticed memory loss.
13. I frequently up wake with a dry mouth.
14. I have difficulty falling asleep.
15. Thoughts race through my mind and prevent me from sleeping.
16. I anticipate a problem with sleep several times a week.
17. I wake up and cannot go back to sleep.
18. I worry about things and have trouble relaxing.
19. I wake up earlier in the morning than I would like to.
20. I lie awake for half and hour or more before I fall asleep.
21. I often feel sad and depressed at night.
22. I have trouble concentrating at work or school or in conversation.
23. When I am angry or surprised, I feel like my muscles are going limp.
24. I have fallen asleep while driving.
25. I often feel like I am in a daze.
26. I have experienced vivid dreamlike scenes upon falling asleep or awakening.
27. I have fallen asleep in social settings such as at the movies or at a party.
28. I have trouble at work because of sleepiness.
29. I have dreams soon after falling asleep or during naps.
30. I have “sleep attacks” during the day no matter how hard I try to stay awake.
31. I have had episodes of feeling paralyzed during my sleep.
32. I wake up at night with an acid/sour taste in my mouth.
33. I wake up night coughing or wheezing.
34. I have frequent sore throats.
34A. I feel nauseous in the morning and/or at night.
35. During the night I suddenly wake up feeling like I am choking.
36. Other than when exercising, I still experience muscle tension in my legs.
37. I have noticed (or others have commented) that parts of my body jerk during sleep.
38. I have been told that I kick at night.
39. When trying to go to sleep, I experience an aching or crawling sensation in my legs.
40. I experience leg pain or cramps at night.
41. Sometimes I can’t keep my legs still at night, I just have to move them to feel comfortable.
42. Even though I slept during the night, I feel sleepy during the day.

**Scoring:**

Questions 1-13: If you marked three or more boxes, you show symptoms of a Sleep Disordered Breathing problem such as Sleep Apnea – a potentially serious disorder that causes you to stop breathing repeatedly during sleep, lowering your blood oxygen levels and disturbing rest.

Questions 14-21: If you marked three or more boxes, you show symptoms of Insomnia – a persistent inability to fall asleep or stay asleep, possibly due to a sleep disordered breathing problem.

Questions 22-31: If you marked three or more boxes, you show symptoms of Narcolepsy or Cataplexy – a disorder characterized by uncontrollable sleep attacks during the day.

Questions 32-35: If you marked two or more boxes, you show symptoms of Gastroesophageal Reflux- a disorder caused by acid “backing up” into the esophagus during sleep, possibly due to a sleep disordered breathing problem.

Questions 36-42: If you marked three or more boxes, you show symptoms of Periodic Limb Movement Disorder- uncontrollable leg or arm jerks during sleep or Restless Leg Syndrome – uncomfortable feelings in the legs at night.
TMJ & SLEEP THERAPY CENTRE
of Conejo Valley

WE'VE MOVED!!! PLEASE SEE BELOW FOR DIRECTIONS.

WEBSITE:  www.tmjconejo.com

Email:  TMJANDSLEEP@Yahoo.com

Driving directions to 555 Marin St, Thousand Oaks, CA 91360 From our OLD LOCATION.

1. Head southeast on St Charles Dr toward W Wilbur Rd
2. Take the 1st right onto W Wilbur Rd
3. Take the 1st right onto Marin St
   Destination will be on the right

FROM THE 101 FREEWAY NORTH
Hwy 101 N/US-101 N/Ventura Fwy
1. Take the Moorpark Rd exit
2. Turn right onto S Moorpark Rd
3. Turn left onto W Hillcrest Dr
4. Turn right onto Marin St

From The 101 FREEWAY SOUTH
1. Take exit Moorpark Rd Exit
2. Turn Left on MoorPark
3. Turn Left onto Hillcrest Dr
4. Turn Right onto Marin ST.