PAIN QUESTIONNAIRE

Name: _____ Date: _____

Briefly describe your main problem: _____

_____

_____

1. Approximately when did your problem begin? _____
2. Did your symptoms start after any of the following? (circle)
   - A. Injury to the jaw
   - B. Injury to the neck
   - C. Injury to the head
   - D. Large bite or yawn
   - E. Dental treatment
   - F. Whiplash
   - G. Orthodontic treatment
   - H. Severe emotional upset
   - I. Any illness
   - J. Other _____

Please explain in detail: _____

_____

_____

3. What were the first symptoms experienced: _____

_____

4. Please rate your overall pain on a scale of 1-10 (where 0 = none and 10 = worse possible)

   0 1 2 3 4 5 6 7 8 9 10

5. Circle the following activities that cause pain or discomfort:
   - A. Yawning/opening wide
   - B. Talking
   - C. Chewing
   - D. Swallowing
   - E. Head and neck movement
   - F. Moving shoulders/arm
   - G. Family/social situations
   - H. School/work
   - I. Allergies
   - J. Other _____

6. What makes your symptoms better?

   _____

7. Do you feel that you need treatment for this problem? ..... ❑ Yes ❑ No
8. Does your jaw problem interfere with your:
   - A. Diet ..... ❑ Yes ❑ No
   - B. Social/family life ..... ❑ Yes ❑ No
   - C. Physical activity ..... ❑ Yes ❑ No
   - D. Work ..... ❑ Yes ❑ No
   - E. Sleep ..... ❑ Yes ❑ No
9. Does this problem affect your hearing? ..... ❑ Yes ❑ No
10. Do you experience dizziness or loss of balance? ..... ❑ Yes ❑ No
11. Does your jaw swing to one side when you open? ..... ❑ Yes ❑ No
12. Does it hurt when you open wide or take a big bite? ..... ❑ Yes ❑ No
13. Do you have difficulty chewing? ..... ❑ Yes ❑ No
14. Does you jaw ever get tired? ..... ❑ Yes ❑ No
15. Do you have problems with other joints? ..... ❑ Yes ❑ No
16. Does your bite feel uncomfortable or uneven? ..... ❑ Yes ❑ No

17. Have you ever had your bite adjusted?..... ❑ Yes ❑ No

18. Are you aware of clenching or grinding your teeth?..... ❑ Yes ❑ No

19. Is there a time of day when your symptoms are worse? (When? _____)..... ❑ Yes ❑ No

20. Does your jaw joint get stuck, lock or "go out"?..... ❑ Right ❑ Left ❑ Both

21. The following questions relate to jaw joint noises that you presently have.

A. Do you have clicking?..... ❑ Right ❑ Left ❑ Both

B. Do you have popping?..... ❑ Right ❑ Left ❑ Both

C. Do you have grating or grinding?..... ❑ Right ❑ Left ❑ Both

22. Do you have pain in the following areas?

A. Face..... ❑ Right ❑ Left ❑ Both

B. Jaw..... ❑ Right ❑ Left ❑ Both

C. Head..... ❑ Right ❑ Left ❑ Both

D. Ear..... ❑ Right ❑ Left ❑ Both

E. Throat..... ❑ Right ❑ Left ❑ Both

F. Neck..... ❑ Right ❑ Left ❑ Both

G. Shoulder..... ❑ Right ❑ Left ❑ Both

23. Headaches:

A. Are headaches a problem? ❑ Yes ❑ No

B. How often do you have headaches? _____

C. How bad are your headaches? (0 = none, 10 = worse possible) 0 1 2 3 4 5 6 7 8 9 10

D. When are your headaches the worst?..... ❑ Morning ❑ Afternoon ❑ Night

E. Do you experience migraine headaches?..... ❑ Yes ❑ No

F. Do you experience a change in vision with your headaches?..... ❑ Yes ❑ No

G. Does chewing cause or increase headache pain?..... ❑ Yes ❑ No

H. Is the headache worse on one side?..... ❑ Right ❑ Left ❑ Equal

24. Neck pain:

A. Is neck pain a problem? ❑ Yes ❑ No

B. How often? _____

C. Does your neck ever make clicking or grating ❑ Yes ❑ No

D. Do you have numbness or weakness in your hands or ❑ Yes ❑ No

E. Is the neck pain worse on one side?..... ❑ Right ❑ Left ❑ Both Equal

25. Have you ever noticed the production of more or less saliva?..... ❑ Yes ❑ No

26. Have you noticed swelling in the cheeks?..... ❑ Yes ❑ No

27. Have you had x-rays taken for this problem? ..... ❑ Yes ❑ No

Where _____ When? _____

Results? _____

28. Have you ever had any of the following as treatment for your problem? (circle)

A. Orthodontia B. Extensive dental treatment C. Splint therapy

D. Jaw joint surgery E. Biofeedback F. Chiropractic care

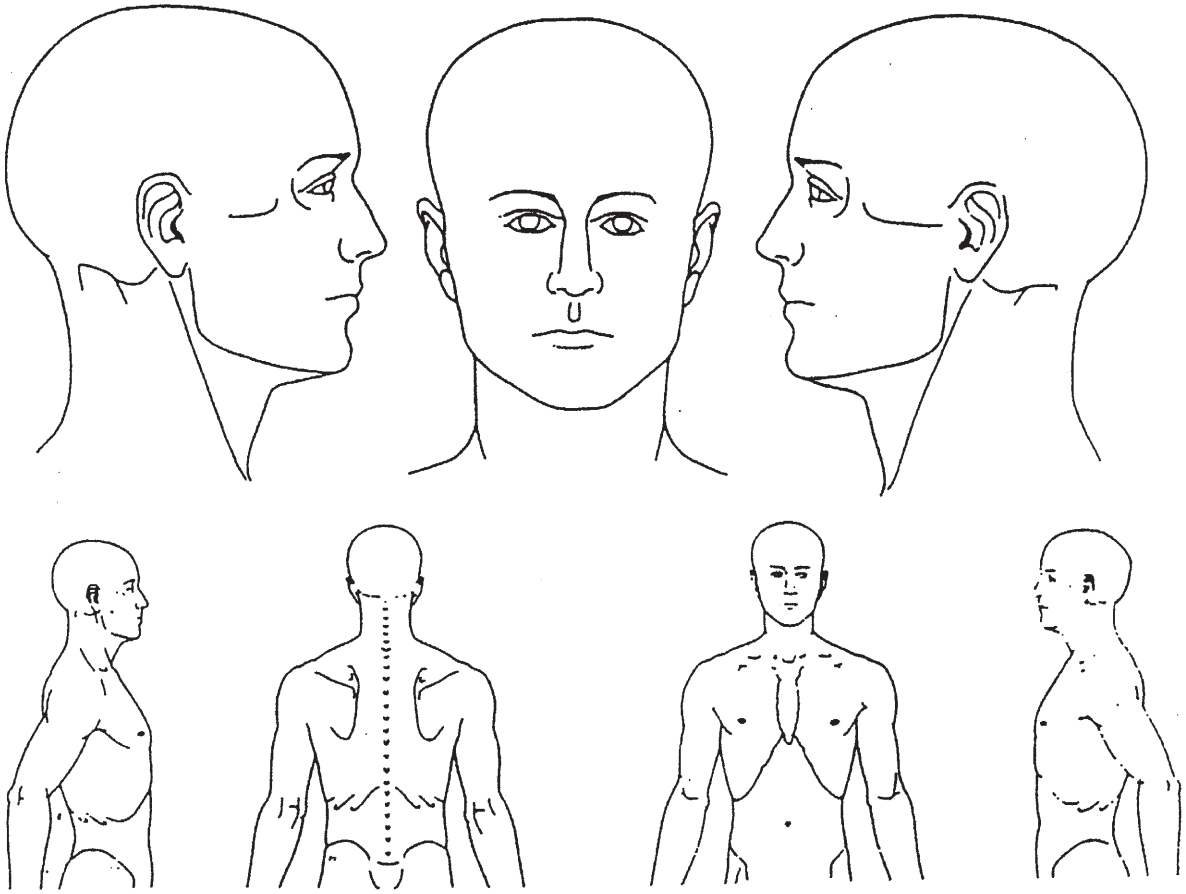
G. Mental health care H. Acupuncture I. Tooth grinding or adjustment

J. Physical therapy K. Other_____

L. Medication (list) _____

29. If you have pain, map your pain on these drawings using the following key:

M=mild pain X=moderate pain S=severe pain ↗ =shooting pain



30. Please list all the health professionals and other clinicians with whom you have consulted for this problem.

Doctor_____ Specialty_____

Addresss_____ Phone_____

Diagnosis and treatment (including dates) _____

_____

_____

Doctor_____ Specialty_____

Addresss_____ Phone_____

Diagnosis and treatment (including dates) _____

_____

_____

Doctor_____ Specialty_____

Addresss_____ Phone_____

Diagnosis and treatment (including dates) _____

Doctor_____ Specialty_____

Addresss_____ Phone_____

Diagnosis and treatment (including dates) _____

Doctor_____ Specialty_____

Addresss_____ Phone_____

Diagnosis and treatment (including dates) _____

31. Please list the name, address, phone and contact person of your insurance company if this problem is accident related:

Insurance Co. _____ Contact Person _____

Address_____ Phone_____

32. Please list the name, address and phone number of your attorney if this problem is accident related:

Attorney_____ Phone_____

Address_____

33. If related to a motor vehicle accident, please complete this section:

A. Date of accident: _____

B. What happened: _____

C. List your symptoms following the accident and when each symptom began:

Symptoms	Date of onset

D. Were you driving?..... ❑ Yes ❑ No

E. Were you wearing a seatbelt?..... ❑ Yes ❑ No

F. Street of the accident: _____

G. Your vehicle make and year: _____

H. Other vehicle make and year: _____

I. Speed of your vehicle:_____

J. Speed of other vehicle: _____

K. Damage to your vehicle: $_____

L. Damage to other vehicle: $_____

M. Did you lose consciousness?..... ❑ Yes ❑ No

N. Were you seen in a hospital?..... ❑ Yes ❑ No

O. Were you taken by ambulance?..... ❑ Yes ❑ No

P. Did any part of your body strike the inside of the vehicle?..... ❑ Yes ❑ No

(explain)_____

_____

Q. List any symptoms that were present <u>prior</u> to the accident and when each symptom began:

_____

_____

_____

R. Did any of your pre-existing symptoms change after the accident? (explain)_____

_____

_____

S. Please draw a map showing streets and direction of travel:

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