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

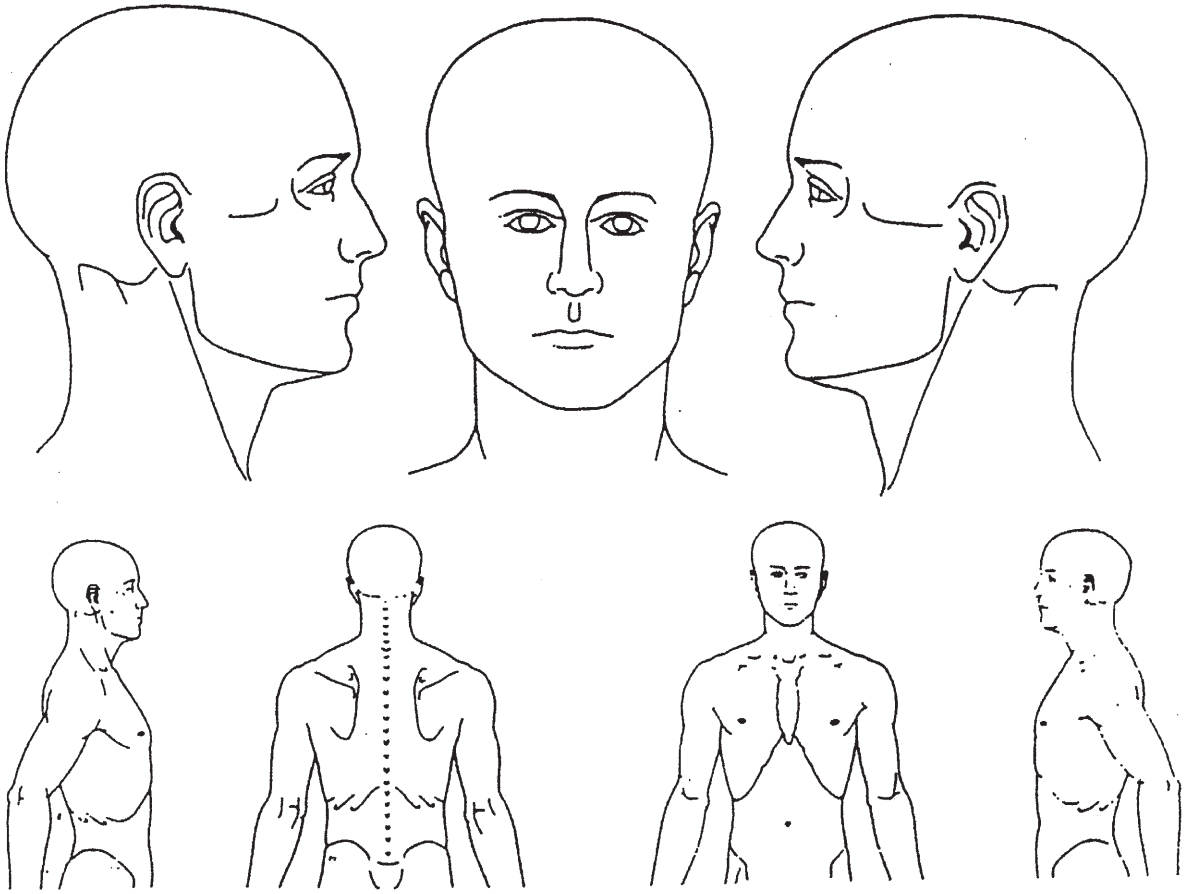
G. Mental health care H. Acupuncture I. Tooth grinding or adjustment

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) _____

Name _____

The Prosthodontic Dental Group

Consent and Permit for Treatment

I hereby authorize Dr. Brock E. Hinton, Dr. Jeffrey Y. Nordlander, and whomever they may designate as their associates, hygienists and assistants to perform upon _____ all necessary procedures and to administer anesthetics related to the examination, diagnosis, and treatment to be performed. I further request and authorize them to do whatever they deem advisable and necessary as a result of unforeseen circumstances.

Conservative therapy for TMJ is a method of treatment, which is successful for the majority of patients. However, success in some cases is only partial, or may fail to control the critical symptoms. When this occurs, other treatment such as surgery is sometimes indicated. If treatment succeeds in controlling the symptoms to a satisfactory degree, we must still remember that the structures are "WEAK" and may be a source of a potential trouble in the future. In addition, the treatment course may not show steady improvement. It is common for patients to have good and bad episodes during treatment until the final result is attained.

Cooperation and following instructions are essential to successful treatment. Failure to comply with your doctor's request may be damaging to jaw joints. This damage may make conservative treatment impossible. The patient must understand that other types of treatment may be necessary in conjunction with appliance therapy. Failure to comply and follow through with all recommended forms of treatment may lead to limited success or complete failure of treatment. This could cause the patient's condition to get worse.

A splint is a processed acrylic appliance, which feels very foreign when initially placed. Generally there is a sense of bulk and a variety of odd sensations that pass within a few days without great effort. The splint will also affect speech, causing distortion of some sounds. This again is a symptom, which generally passes within a week or so. You may be instructed to eat with your appliance. This is a difficult adjustment for most people to make but with perseverance it is possible and eventually eating can be done without effort.

The splint will increase plaque accumulation on your teeth. For this reason it is necessary to be extra thorough in your tooth brushing and flossing, especially around the tongue side of the teeth. When you clean your teeth, the splint should be brushed at the Same time. Cleaning the splint with a toothbrush and toothpaste, or soap and water is an effective way of maintaining proper hygiene.

If it is necessary for you to wear your splint 24 hours a day and to eat with it, then repositioning of the lower jaw will probably occur. This is often a necessary process in the treatment of jaw joint problems. This change in position of the lower jaw results in alteration of the bite relationship between the upper and lower teeth. Generally there is a space that develops between the upper and lower teeth. Closing this space may require some form of dental treatment after control of the joint symptoms is achieved. The exact type of treatment needed varies from individual to individual, depending on the condition of the teeth and amount of change in the bite that has occurred. Treatment that is commonly necessary includes adjusting the bite by grinding the teeth, placing dental restorations such as crowns on some or all of the teeth, orthodontic care (braces), making new dentures or partials and orthognathic (jaw) surgery.

When treatment for jaw problems is needed but not carried out, there is potential for the problem to get worse. This may take the form of an increase in pain, joint symptoms such as clicking, popping and locking, future deterioration of the jaw joints and/or the disc in the joint, and an increase in spasm and dysfunction of the head and neck musculature. Avoiding or postponing treatment may also compromise the result which otherwise might have been attained.

CONSENT AND PERMIT FOR TREATMENT

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The nature, purpose, and risk of the procedures and possible alternative methods of treatment will or have been fully explained to me. I understand that there is a possibility of complications developing during or after any type of dental treatment. These include but are not limited to pain, numbness, tooth and soft tissue sensitivity, devitalization of teeth, infection, tissue recession, injuries to the soft issues which include lips, gums, cheeks, and tongue, fracture to teeth, damage to a healthy tooth, jaw joint pain/problems, allergic reactions to materials used in the temporary and final restorations, and allergic reactions to anesthetics, medications and materials used in diagnosis or treatment.

I understand that with appliance therapy it is probable that following the use of the appliance, future treatment will be required. This may include but is not limited to adjustment of the dentition, placement of crowns and bridges and/or removable prostheses, orthodontic treatment and procedures involving jaw surgery. In order to arrive at a final diagnosis, it may be necessary to be referred to other health care practitioners for further evaluation and treatment.

I understand that appliance therapy is a form of diagnosis and that an appliance is used as a diagnostic tool to help determine the role malocclusion plays in the overall problem.

I understand that appliance therapy may not help me at all and could even cause my symptoms to increase and my problem to get worse.

I have read the above and accept responsibility for these and/or any other complications which may arise or result during or following the procedures which are to be performed at my request. I have not been given, or received any guarantee as to results to be obtained. I am now giving my free and voluntary informed consent for treatment to be rendered. I agree that if I fail to follow through with all recommended treatment, my treatment can be discontinued at any time.

Patient Signature

Legal Guardian if patient is a minor

Witness

Date