

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 your 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) _____

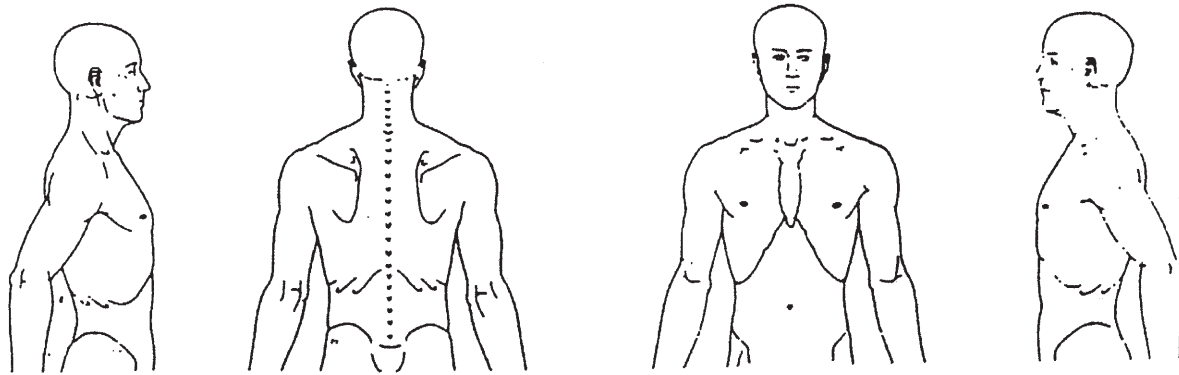
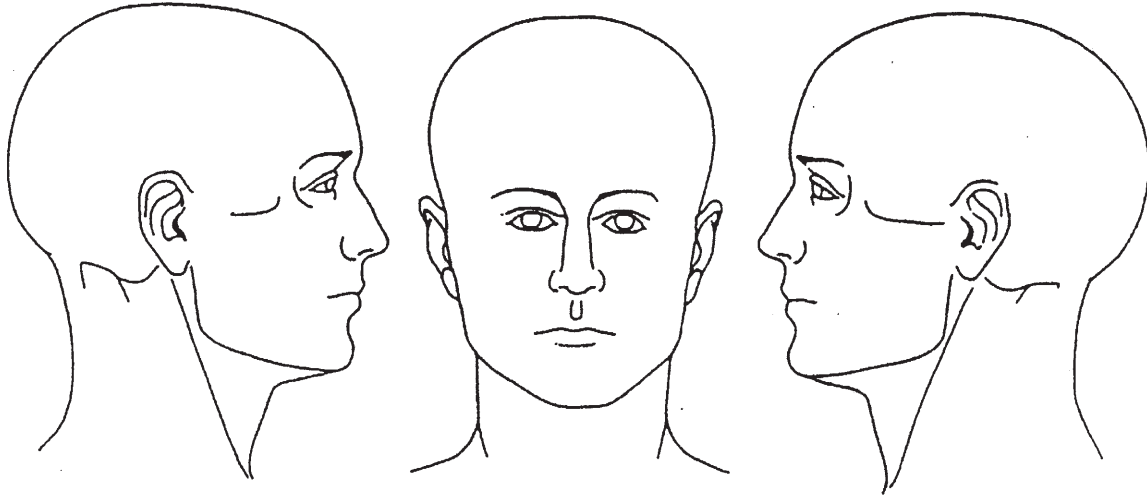
29. If you have pain, map your pain on these drawings using the following key:

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 _____

Address _____ Phone _____

Diagnosis and treatment (including dates) _____

Doctor _____ Specialty _____

Address _____ Phone _____

Diagnosis and treatment (including dates) _____

Doctor _____ Specialty _____

Address _____ Phone _____

Diagnosis and treatment (including dates) _____

Doctor _____ Specialty _____

Address _____ Phone _____

Diagnosis and treatment (including dates) _____

Doctor _____ Specialty _____

Address _____ 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

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 prior 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: