Facial Problem Questionnaire

I. Name _________________________________________ Age________
   Date ___________ Referred by _______________________________

II. Which of the following do you have (circle all that apply)
   Headaches    Neck Pain    Jaw pain    Ear Pain
   Facial Pain   Bite Problems Damaged teeth
   Other _____________________________________

III. Please shade in where your pain is located:

IV. How long have you had this pain? _____________________________
   Is the pain constant? _____________________________
   Is the pain (circle all that apply) Aching Burning
   Stabbing Sharp Dull Other _____________
   Is the pain worse in the (circle all that apply)
   Morning Afternoon Evening Night
   What makes the pain better? __________________________________
   _________________________________________________________
   What makes the pain worse? _________________________________
   _________________________________________________________

How severe is your pain? Please make a mark along the line below:

No Pain ________________________________________________ Worst Pain Ever
V. What medication do you take or have you previously taken for your pain?

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>FREQUENCY</th>
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VI. Does it hurt to move your jaw? Y N
Does it hurt to chew? Y N
Any discomfort upon chewing hard foods like carrots? Y N
Do your jaw muscles get tired from chewing? Y N
Does it hurt to open wide? Y N
Which side of your jaw makes a popping sound? R L
Which side of your jaw makes a clicking noise? R L
Which side of your jaw makes other noises? R L
What Noises? ______________________________________
When did you first notice the noises? ____________________

VII. Have you ever not been able to open your jaw all the way? Y N
Have you ever had to wiggle your jaw to get it open? Y N
Has your jaw ever been stuck open and you could not close it? Y N
When did this first happen? ___________________________
When did this last happen? ___________________________

VIII. Have you noticed a change in the Y N
    way your teeth come together?
Have you noticed your teeth shifting? Y N
Has the shape of your face changed? Y N
Has your chin shifted to one side of your face? Y N
When did you notice any of the above changes?____________

IX Do you get headaches? Y N How often? __________
How long do they last? __________
Where does it ache? ___________________________________
IX. Are your teeth sore or sensitive?  
   Y  N  
Do you clench your teeth?  
   Y  N  
Do you grind your teeth?  
   Y  N  
Do you do this during the day or night?  
   Day  Night  
When did you start clenching or grinding? ____________________  

X. Which of the following dental procedures have you had (please circle):  
   Fillings  Orthodontics  Root Canal  
   Crowns  Bridges  Bite Adjustment  
If you had braces, how many times were you in braces? _______  
   How old were you when you got braces? _______  
   How old were you when you were done? _______  
Have you ever had a tooth extracted?  Y  N  
Have you ever split or broken a tooth?  Y  N  
Do you feel there is any connection between the dental work you have had done and the problems you are having?  Y  N  

XI. Have you ever injured or sustained any form of trauma or whiplash to your (circle all that apply)  
   Jaw  Head  Neck  
   None of the above  
(If so please complete the trauma questionnaire)  
Do you feel there is any connection between the trauma you have had and the problems you are having?  Y  N  

XII. Do you have problems with your ears?  Y  N  
   Dizziness?  Y  N  
   Ringing?  Y  N  
   Hearing?  Y  N  
   Other? _______________  
Is it difficult to swallow?  Y  N  
Is it painful to swallow?  Y  N  
Have you noticed any lumps in your face?  Y  N  
   Throat?  Y  N  
   Neck?  Y  N
XIII. Have you had any changes in your vision?  Y  N
Do you get visual disturbances along with headaches?  Y  N
When was the last time you had your eyes checked? __________

XIV. Do you have trouble sleeping?  Y  N
Do you feel rested when you wake up?  Y  N
How many hours do you sleep? _________
How long does it take you to fall asleep? _________
How many times do you awaken during the night? _________
Do you consider yourself under a lot of stress?  Y  N
Do you worry?  Y  N
Do you ever get depressed?  Y  N
How often? _______________________________________

Have you ever had a stomach problem?  Y  N
Ulcers?  Y  N

Rate the nutrition of your diet:
Excellent  Could be better  Poor

Do you use vitamin supplements?  Y  N
Do you exercise?  Y  N

XV. Do you have or have you had arthritis?  Y  N
Have you been treated for any other painful condition in the last three years other than your present problem?  Y  N

Explain __________________________________________

On the diagram below please indicate any other areas that are painful:
XVI. Have you had any prior treatment for TMJ problems?  Y  N
Appliance/Splint? Y  N  When? ________ Did it help? Y  N
Nightguard?  Y  N  When? ________ Did it help?  Y  N
Bite adjustment?  Y  N  When? ________ Did it help?  Y  N
Orthodontics?  Y  N  When? ________ Did it help?  Y  N
Other ____________________________________________________
____________________________________________________

XVII. Please list, in chronological order, health care providers
you have seen for this problem:

<table>
<thead>
<tr>
<th>Date</th>
<th>Doctor or provider</th>
<th>Treatment</th>
<th>Did it help?</th>
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<tbody>
<tr>
<td></td>
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<td>Y  N</td>
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<td>Y  N</td>
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XVIII. Describe the problem (s) in your own words:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

XIX. How have these problems affected your life? Does it keep you from doing
anything that you want to do? (work, play, chores, eating, talking)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What would you like to accomplish with treatment here?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
XX. Is there anything else that I should know about?


XXI. So that I can better understand your pain, please complete the following:
What does your pain feel like? Some of the words below describe your present pain.
Circle all the words that describe it.

<table>
<thead>
<tr>
<th>Flickering</th>
<th>Jumping</th>
<th>Pricking</th>
<th>Sharp</th>
<th>Pinching</th>
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<tbody>
<tr>
<td>Quivering</td>
<td>Flashing</td>
<td>Boring</td>
<td>Cutting</td>
<td>Pressing</td>
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<tr>
<td>Pulsing</td>
<td>Shooting</td>
<td>Drilling</td>
<td>Lacerating</td>
<td>Gnawing</td>
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<td>Throbbing</td>
<td></td>
<td>Stabbing</td>
<td></td>
<td>Cramping</td>
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<tr>
<td>Beating</td>
<td></td>
<td>Lancinating</td>
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<td>Crushing</td>
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<tr>
<td>Pounding</td>
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<tr>
<th>Tugging</th>
<th>Hot</th>
<th>Tingling</th>
<th>Dull</th>
<th>Tender</th>
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<tbody>
<tr>
<td>Pulling</td>
<td>Burning</td>
<td>Itchy</td>
<td>Sore</td>
<td>Taut</td>
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<tr>
<td>Wrenching</td>
<td>Scalding</td>
<td>Smarting</td>
<td>Hurting</td>
<td>Rasping</td>
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<tr>
<td>Searing</td>
<td>Stinging</td>
<td>Aching</td>
<td>Splitting</td>
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<tr>
<td>Searing</td>
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<thead>
<tr>
<th>Tiring</th>
<th>Sickening</th>
<th>Fearful</th>
<th>Punishing</th>
<th>Wretched</th>
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<tbody>
<tr>
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<td>Frightful</td>
<td>Grueling</td>
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<td>Terrifying</td>
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<td></td>
<td></td>
<td>Vicious</td>
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<table>
<thead>
<tr>
<th>Annoying</th>
<th>Spreading</th>
<th>Tight</th>
<th>Cool</th>
<th>Nagging</th>
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<tbody>
<tr>
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<td>Numb</td>
<td>Cold</td>
<td>Nauseating</td>
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<td>Intense</td>
<td>Piercing</td>
<td>Squeezing</td>
<td>Dreadful</td>
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<td>Tearing</td>
<td>Torturing</td>
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