

Facial Problem Questionnaire

I. Name _____ Age _____

Date _____ Referred by _____

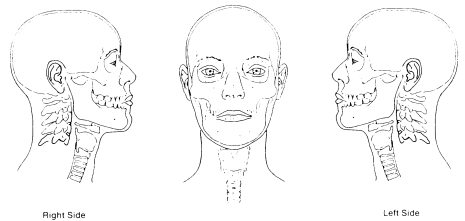
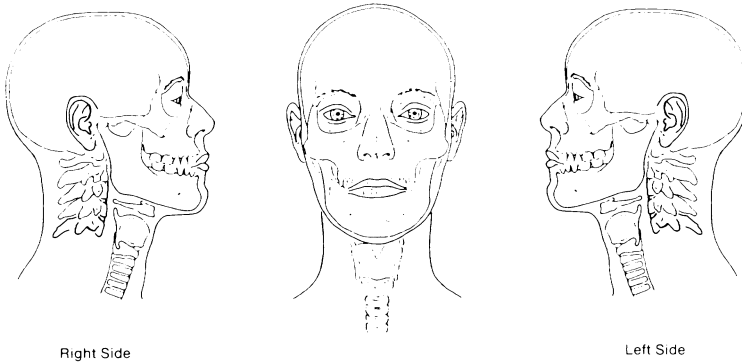
II. Which of the following do you have (circle all that apply)

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? _____

Please do not write in this space.

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?

MEDICATION	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

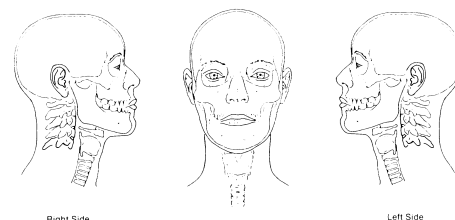
Please do not write in this space.

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. Are you aware of or ever think about the way your teeth come together (your bite)? Y N
 Have you noticed a change in the way your teeth come together? Y N
 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? _____



Please do not write in this space.

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

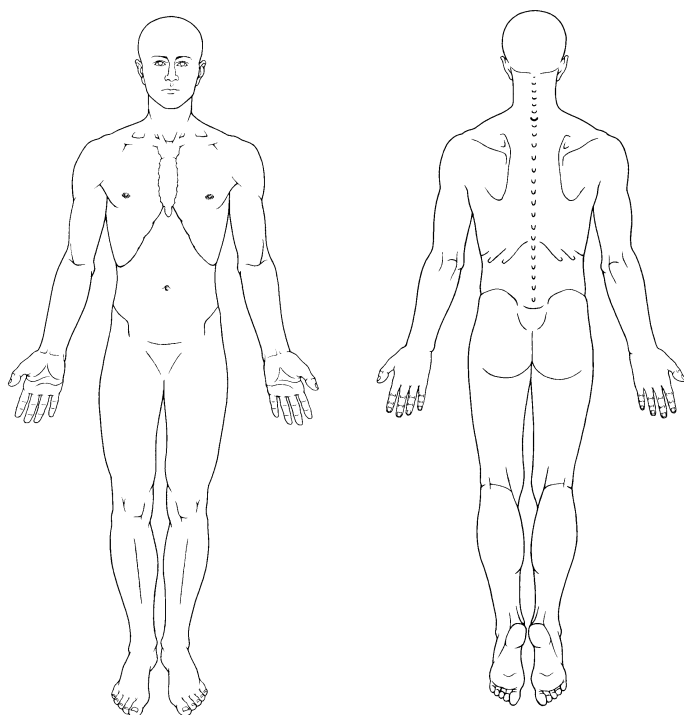
Is it painful to swallow? Y N

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 _____

Please do not write in this space.



Please do not write in this space.

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:

<u>Date</u>	<u>Doctor or provider</u>	<u>Treatment</u>	<u>Did it help?</u>
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N
_____	_____	_____	Y N

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.

Flickering	Jumping	Pricking	Sharp	Pinching
Quivering	Flashing	Boring	Cutting	Pressing
Pulsing	Shooting	Drilling	Lacerating	Gnawing
Throbbing		Stabbing		Cramping
Beating		Lancinating		Crushing
Pounding				
Tugging	Hot	Tingling	Dull	Tender
Pulling	Burning	Itchy	Sore	Taut
Wrenching	Scalding	Smarting	Hurting	Rasping
Searing	Stinging	Aching	Splitting	
			Heavy	
Tiring	Sickening	Fearful	Punishing	Wretched
Exhausting	Suffocating	Frightful	Grueling	Blinding
		Terrifying	Cruel	
		Vicious		
Annoying	Spreading	Tight	Cool	Nagging
Troublesome	Radiating	Numb	Cold	Nauseating
Miserable	Penetrating	Drawn	Freezing	Agonizing
Intense	Piercing	Squeezing		Dreadful
Unbearable		Tearing		Torturing

XXII. Please list any doctors names, phone numbers and addresses that I may need:

XXIII. I have completed all 6 pages to the best of my knowledge and I personally have filled in each blank in my own writing.

signature

date