TMJ, HEADACHE AND FACIAL PAIN QUESTIONNAIRE

This questionnaire is designed for you to provide important facts regarding the history of your pain or condition. The information you provide will assist in your treatment plan design.

Full Name :

Email: Date of Birth:

PAIN HISTORY

When did your condition first occur?

What do you believe is the cause of your pain or condition?

- ☐ Motor vehicle accident
- ☐ Accident
- ☐ Work related incident
- ☐ Injury
- ☐ Fight
- ☐ Illness
- ☐ Unknown
- ☐ Other:

If accident, date:

Have you had jaw surgery?

- ☐ Yes
- ☐ No

Have you had prior orthodontic treatments?

- ☐ Yes
- ☐ No

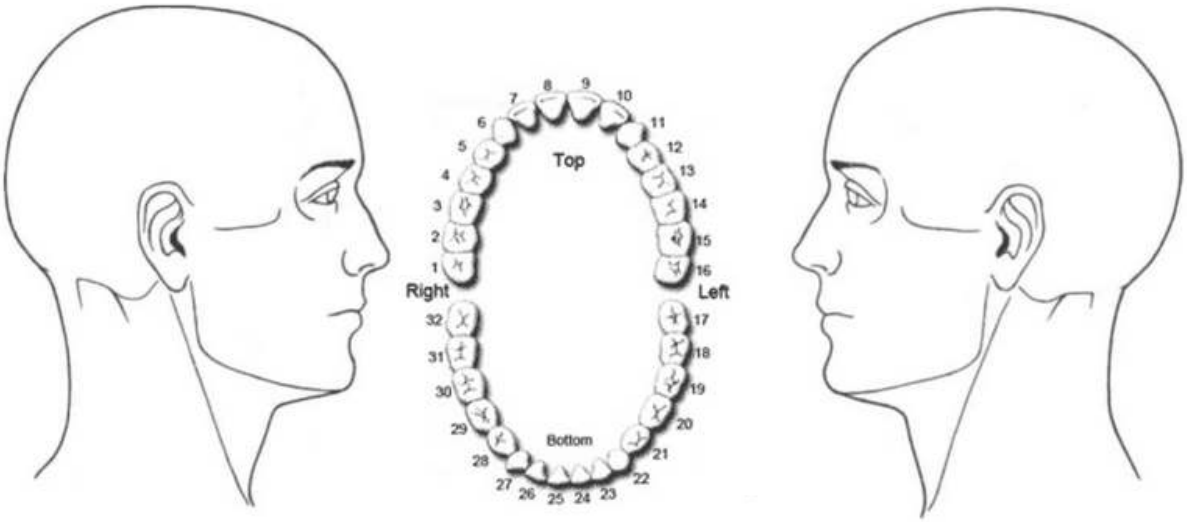
Have you had teeth removed before having braces?

- ☐ Yes
- ☐ No

WHERE IS YOUR PAIN?

Shade using strokes for MILD pain ////////

Shade using cross for STRONG pain XXXXX



Do you get pain or sensitivity in any teeth? Please mark the image.

DESCRIBE YOUR JAW PAIN

1) Is your pain:

- ☐ Sharp/stabbing
- ☐ Hot
- ☐ Throbbing

2) Does your jaw pain worsen during chewing?

- ☐ Yes ☐ L ☐ R ☐ B
- ☐ No

3) Do you have jaw pain at the start of opening?

- ☐ Yes ☐ L ☐ R ☐ B
- ☐ No

4) Does your jaw feel stiff or ache upon waking?

- ☐ Yes ☐ L ☐ R ☐ B
- ☐ No

5) Do you have jaw pain at rest?

- ☐ Yes ☐ L ☐ R ☐ B
- ☐ No

6) Does your pain feel...

- ☐ Dull/bruised
- ☐ Dragging

SLEEP QUESTIONS

7) Do you feel you get enough sleep?

- ☐ Yes
- ☐ No

8) On waking do you feel...

- ☐ Tired and foggy
- ☐ Refreshed and alert

9) Do you feel fatigued or tired during the day?

- ☐ Yes
- ☐ No

10) Has anyone ever told you that you snore?

- ☐ Yes
- ☐ No

11) Does it take you a long time to fall asleep?

- ☐ Yes
- ☐ No

12) Do you wake during the night?

- ☐ Yes
- ☐ No

BREATHING AND AIRWAY QUESTIONS

13) Does your mouth or throat feel dry on waking?

- [ ] Yes
- [ ] No

14) Do you have allergies or frequent sinus congestion?

- [ ] Yes
- [ ] No

15) Are your lips closed when breathing normally?

- [ ] Yes
- [ ] No

16) Do you clench or grind your teeth?

- [ ] Yes
- [ ] No

17) Do you have difficulty breathing through your nose?

- [ ] Yes
- [ ] No

CHRONIC PAIN QUESTIONS

18) Do you have widespread pain in muscles or joints?

- [ ] Yes
- [ ] No

19) Do dental visits cause you anxiety or trigger off any pain?

- [ ] Yes
- [ ] No

20) Do you suffer from depression or anxiety?

- [ ] Yes
- [ ] No

EXERCISE QUESTIONS

21) Do you exercise regularly?

- [ ] Daily
- [ ] Every second day
- [ ] 1x per week

22) What is your preferred form of exercise?

Is there anything that makes your pain or discomfort worse? _____

Is there anything that makes your pain or discomfort better? _____

Have you had any treatment for your pain in the past? _____

Which treatment has helped the most? _____

DESCRIBE YOUR HEADACHE SYMPTOMS

Do you get frequent headaches?

- [ ] Yes
- [ ] No - do no complete this section

How often do you get headaches?

- [ ] Daily
- [ ] Weekly
- [ ] Monthly

Do you have neck or shoulder pain?

- [ ] Yes [ ] L [ ] R [ ] B
- [ ] No

Have you had neck surgery?

- [ ] Yes
- [ ] No

Do you get numbness or tingling in your fingers?

- [ ] Yes
- [ ] No

Do you get numbness or tingling in your head or face?

- [ ] Yes
- [ ] No

Tick any symptoms that you get?

- [ ] Sinus pain or congestion
- [ ] Blurred vision
- [ ] *Dots, lines or blind spots in vision (aura)*
- [ ] *Light sensitivity*
- [ ] Dizziness
- [ ] Loss of balance
- [ ] Nausea without vomiting
- [ ] *Nausea with vomiting*
- [ ] Symptoms feel better with heat
- [ ] Tinnitus, ringing or noise in the ear(s)
- [ ] Hearing loss or ear fullness
- [ ] Excessive watering of the eye (ptosis)
- [ ] Sore throat
- [ ] Persistent throat cough
- [ ] *Symptoms feel better with cold*
- [ ] Symptoms feel better with heat
- [ ] *The pain throbs like it has a pulse*

Is there anything that makes your pain or discomfort worse? _____

Is there anything that makes your pain or discomfort better? _____

Have you had any treatment for your pain in the past?

- [ ] Medication/drugs
- [ ] Physiotherapy
- [ ] Osteopathy
- [ ] Chiropractic
- [ ] Massage
- [ ] Acupuncture
- [ ] Dental splint/mouth guard
- [ ] Exercises

Which treatment has helped the most? _____

What other information is important to your pain or condition? _____