

Facial Problem Questionnaire

Name _____ Age _____

Date _____ Referred by _____

Referring Dr.'s Phone # and Email: _____

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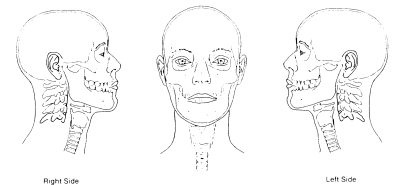
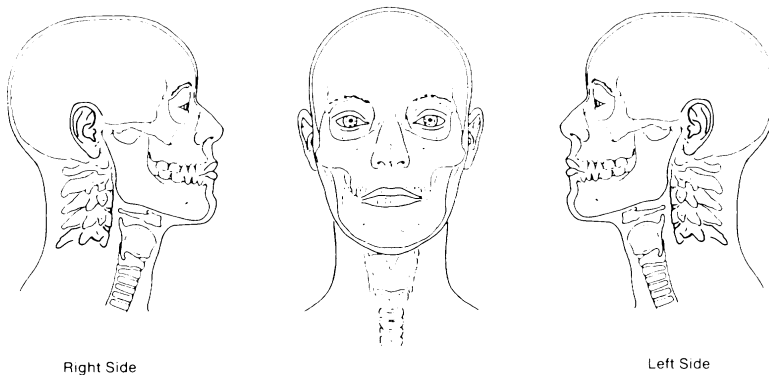
Date _____

1. Which of the following do you have (circle all that apply)
- Headaches Neck Pain Jaw pain Ear Pain
- Facial Pain Bite Problems Damaged teeth Sleep Problem
- Other _____

2. How many days a month are you pain free? _____

If pain free, go to next page.

If Pain, Please shade in where your pain is located:



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

What medication do you take or have you previously taken for your pain?

MEDICATION

DOSE

FREQUENCY

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please do not write in this space

		<u>Yes</u>	<u>No</u>
3.	Any discomfort when you chew?	Y	N
	Which side do you favor chewing on ?	R	L Use Both
	Is it difficult or painful to swallow?	Y	N
	Any discomfort when you move your jaw?	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 clicking/popping noise?	R	L neither
	Which side of your jaw makes other noises?	R	L neither
	What Noises? _____		
	When did you first notice the noises or clicking? _____		
	Have you noticed any changes in noises or clicking?	Y	N
	Explain: _____		
4.	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? _____ Last happen? _____		
5.	Has your speech changed?	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? _____		
6.	Do you have a hyper-sensitive bite?	Y	N
	Is your bite uncomfortable?	Y	N
	When you close your jaw, do you have to search for		
	a comfortable position for your teeth to fit?	Y	N

Chew
Swallow
Speak
Open/Close

Healthy
Damaged
Active breakdown
Adapting
Adapted

Favorable
Unfavorable

TMJ Move

Structurally Stable

Mech Stable

Occl

7. Are your teeth sore or sensitive? Y N
 Do you clench your teeth? Y N
 Do you grind your teeth? Y N
 Do you grind or clench during the day or night? Day Night Both Neither
 When did you start clenching or grinding? _____

8. Do you have a dentist who you see for routine care and cleanings? Y N
 Please list : _____ Last Visit: _____

Which of the following dental procedures have you had (please circle):

Fillings Orthodontics Root Canal Dentures
 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

9. Have you ever injured or sustained any form of trauma or whiplash to your:
 (circle all that apply) Jaw Head Neck None of these
 (If any past trauma, please complete the trauma questionnaire)

Have you ever had stitches to your chin? Y N

Do you feel there is any connection between the trauma
 you have had and the problems you are having? Y N

10. Do you get headaches? Y N How often? _____
 How long do they last? _____
 Where does it ache? _____

11. Have you had any changes in your vision? Y N
 Do you get visual disturbances along with headaches? Y N
 Do you have problems with your ears? Y N
 Dizziness? Y N Ringing? Y N
 Hearing? Y N Other? _____
 Have you noticed any lumps in your face, throat or neck? Y N
 Do you typically breath through your mouth instead of your nose? Y N
 Do you have any sinus problems? Y N
 Explain: _____

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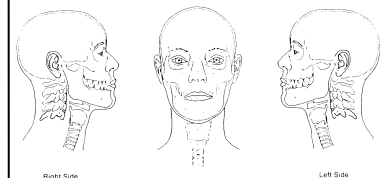
Parafunction

PDHx

Ortho

Trauma

HeadA

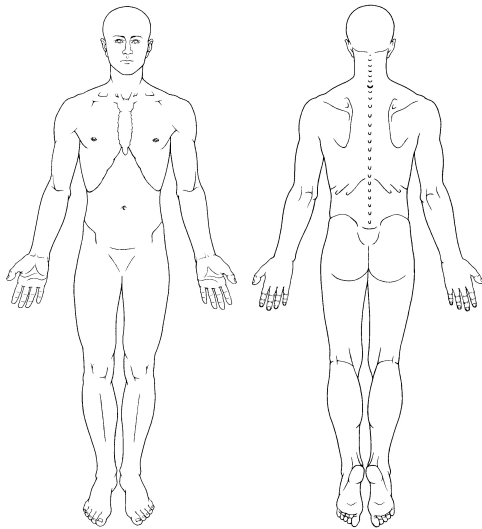


ENT

12. Do you have trouble sleeping? Y N
Do you feel rested when you wake up? Y N
13. Do you have or have you had arthritis? Y N
Does anyone related to you have arthritis? Y N
Are your fingers sore or stiff? Y N
Any dry skin patches past or present? Y N
Any skin rashes past or present? 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:



14. Have you had any prior treatment for TMJ problems? Y N
Appliance/Splint? Y N When? _____ Did it help? Y N
Night guard? 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 _____

15. Please list, in chronological order, health care providers you have seen for the problem you are presenting with today:

<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
_____	_____	_____	Y N

Please do not write
in this space

17. Describe the problem (s) in your own words:

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?

18. What has Changed and When:

So that I may have a better understanding of your problem, please list in chronological order with date estimates all the changes and/or defining moments of your problem.

(Examples are: fell down stairs, left TMJ clicking started, clicking stopped, teeth shifted, headaches increased, headaches stopped, left ear pain.)

Date EstimateChange that Occurred[illegible]

19. Is there anything else that I should know about?

20. 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

21. I have completed all 8 pages to the best of my knowledge and I personally have filled in each blank.

signature

date