FACIAL PAIN/TEMPOROMANDIBULAR JOINT QUESTIONNAIRE

Once the questionnaire is returned to the office we will gladly arrange a consultation appointment regarding your condition. Please take the time to answer this questionnaire carefully as it is important to help better diagnose and manage your condition.

Please note there is a CONSULTATION FEE and a possible XRAY FEE. These fees are payable at the time of visit and are not usually covered by dental or medical plans.

Name: ___________________ Age: _______ D.O.B _______ Telephone _____________
Address: ___________________ City: ___________ Postal Code: _____________

Referred by: ___________________
Others who are or have been treating this problem
Doctor: ___________________
Doctor: ___________________

PLEASE CIRCLE APPLICABLE ANSWERS:

1. Your problem is in your; ear/ jaw/ jaw-joint/ face/ teeth/ neck/ eye/ back of head other__________________________

2. When did you first notice this problem? ________________________________

3. It is located in the right/ left/ both sides?
Describe location ________________________________

4. Would you call it pain / simple concern / suffering other (describe) ________________________________

5. Record the level of your pain on this scale.
mild 1 2 3 4 5 6 7 8 9 10 worst

6. yes no Does pain or discomfort interfere with daily activities?

7. yes no Is this pain constant?

8. yes no Intermittent pain?

9. yes no Burning pain?

10. yes no Dull, aching pain?

11. yes no Stabbing, severe pain?
12. yes  no  Electrical, shooting pain?
13. yes  no  Does it hurt when you chew? Where?
14. yes  no  Does it hurt to open wide?
15. yes  no  Do you have joint sounds? Describe
16. yes  no  Have you been able to relieve or diminish the symptoms? Circle: rest / heat / medication / splint / other
18. yes  no  Do you have headaches?
19. yes  no  Does time of day affect the condition? Circle: morning / evening / sleeping / mealtime.
20. yes  no  Do you have jaw habits? Circle: grinding / clenching / testing jaw / biting fingernails other
21. yes  no  Do you have chronic; back / neck / shoulder pain?
22. yes  no  Do you notice any of the following?
   __Hearing loss     right / left
   __Pain in teeth in a.m. right / left
   __Headaches       right / left
   __Neck Pains      right / left
   __Popping, clicking, grinding noise right / left
   __Stiffness in ears right / left
   __Ringing in ears right / left
   __Dizziness       right / left
   __Swallowing problems right / left
   __Locking open    right / left
   __Locking closed  right / left
23. yes  no  Do you recall any jaw trauma such as an accident? Describe:
24. yes  no  Have you ever had any “Whiplash”? When
25. yes  no  Have you had jaw surgery? Describe
26. yes  no  Have you had orthodontics?
27. yes  no  Have you ever been treated for ulcers?
28. yes  no  Have you ever been treated for depression?
30. yes  no  Are you under litigation for this problem?
31. yes  no  Have you had x-rays for this problem?
32. List all medications currently in use:________________________________________
                      ________________________________________________________________
33. List all other medications used within the last year:__________________________
                      ________________________________________________________________
34. What do you think caused this problem and what do you think is the problem?
                      ________________________________________________________________
35. What does this problem keep you from doing?_______________________________
                      ________________________________________________________________
36. Other pertinent comments that you wish to add:_______________________________
                      ________________________________________________________________
                      ________________________________________________________________
                      ________________________________________________________________
To the best of my knowledge this information is correct:

___________________________  ________________________________
Patient’s signature          Date

Please return completed form so that we may arrange an appointment.

Please bring “Splint” if applicable