Pain Questionnaire

Revised 01/24/18

Date _____

Patient name _____
Last First Middle

Address _____

Telephone no._____

City _____State _____ Zip _____ Office

Age _____ Sex: Male _____ Female

Family Physician _____

Family Dentist _____

Marital status:

___ Married ___ Divorced ___ Separated

___ Single ___ Co-habit ___ Widow/widower

Number of children _____ ages _____

Are you presently employed? _____ Yes _____ No

Occupation _____

Who referred you to our office: _____

Address and telephone: _____

1. Chief complaint: (What problems bring you to this office?)

_____

2. Do you know what caused you to have pain? _____

2.5 Describe in order (first to last), what you expect from treatment._____

_____

_____

_____

2.75 How would you describe your overall physical health?

Poor Average Excellent

0 1 2 3 4 5 6 7 8 9 10

How would you describe your overall dental health?

Poor Average Excellent

0 1 2 3 4 5 6 7 8 9 10

3. Have you ever been examined for a TMD problem before? ____ Yes ____ No
If yes, by whom & when? _____
_____
_____

4. Do you have pain in your face or jaw? _____ Yes _____ No
Using the rating scale indicate the severity of the pain you are experiencing by circling the appropriate area:

0 1 2 3 4 5 6 7 8 9 10

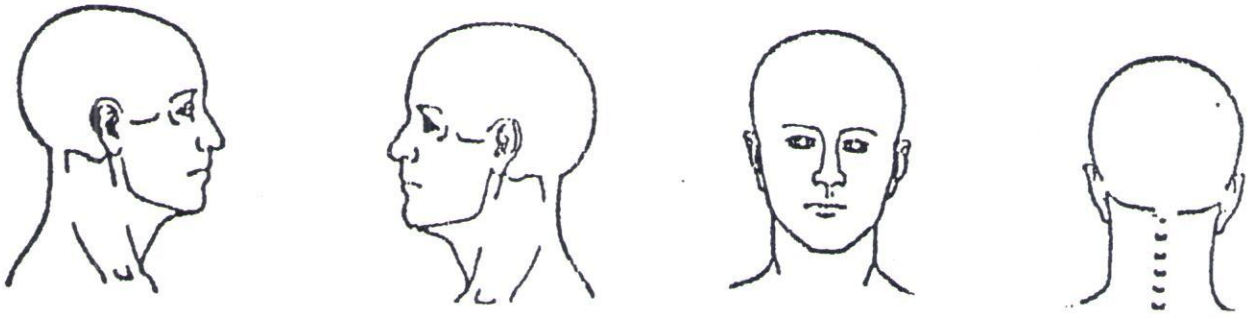
no pain extreme pain

5. Describe the pain:

_____ Dull	_____ Aching	_____ Burning/Hot
_____ Throbbing	_____ Pressure	_____ Pulsating
_____ Stabbing	_____ Sharp	_____ Punishing/Cruel
_____ Tiring/Exhausting	_____ Sickening	_____ Other

6. Does the pain radiate, travel, or move from the area of initial pain?
_____ Yes _____ No
_____ Pain moves up the side of the head
_____ Pain moves around to the back of the head
_____ Pain moves down the neck

7. On the diagrams please circle the areas where you have pain: **VERY IMPORTANT**



8. How long have you had this pain?
   Number of : _____ years; _____ months; _____ weeks

9.. When do you have pain?
   _____ Constantly
   _____ Frequently but not predictable
   _____ Frequently and predictably
   _____ Occasionally
   _____ No real pattern

10. Is there a pattern to your pain? _____Yes_____No
    If yes, please circle when your pain occurs.
    1. Mostly Day?/Mostly Evening? 2. Hormonally related
    3. Work days 4. School Days
    5. Other _____

11. How long does the pain last?
    _____ Less than 1 minute
    _____ 1-10 minutes
    _____ Less than 1 hour
    _____ 1-5 hours
    _____ 6-12 hours
    _____ 13-24 hours
    _____ Several days
    _____ Constant

12. Do you have numbness or unusual feelings or sensations in your face or jaw?
    _____ Yes _____ No

13. Do any of the following cause or aggravate the pain?
    _____ Chewing
    _____ Opening mouth wide
    _____ Talking
    _____ Sitting for a long period of time
    _____ Other
    _____ Yawning
    _____ Laughing
    _____ Singing
    _____Exercise
    _____Lack of sleep
    _____Playing musical instrument
    _____Eating certain foods
    _____ Stress/emotional upset

14. What relieves the pain?
    _____ Massage of the area
    _____ Warm soaks compresses
    _____ Holding jaw in certain positions
    _____ Pain medication
    _____ Moving or manipulating jaw
    _____ Other
    _____ Sleep
    _____ Time
    _____ Relaxation
    _____ Heat
    _____ Ice/Cold Compresses

15. Check any of the following that you experience.

[ ]Numbness in the face or jaw
[ ]Earache
[ ]Ear stuffiness
[ ] Ringing or buzzing in ears
[ ]Aches and pains all over body
[ ]Unusual tastes
[ ]Change in ability to taste
[ ]Numbness/tingling in hands or fingers
[ ]Weakness in jaw muscles
[ ]Easily Fatigued
[ ]Dizziness
[ ]Pain in the back of the head
[ ]Morning Stiffness
[ ]Jaw catching
[ ]Decreased ability to open mouth

15. Do you have pain in the cheek? _____ Yes _____ No
Which side? _____ Right; _____ Left; _____ Both sides
Using the rating scale indicate the severity of the pain you are experiencing by circling the appropriate area:

0 1 2 3 4 5 6 7 8 9 10

no pain extreme pain

16. Do you have pain in the temple or above the ear?
_____ Yes _____ No
Which side? _____ Right; _____ Left; _____ Both sides
Using the rating scale indicate the severity of the pain you are experiencing by circling the appropriate area:

0 1 2 3 4 5 6 7 8 9 10

no pain extreme pain

17. Do you have pain in your neck? _____ Yes _____ No
Using the rating scale indicate the severity of the pain you are experiencing by circling the appropriate area:

0 1 2 3 4 5 6 7 8 9 10

no pain extreme pain

18. Do you have pain in your back? _____ Yes _____ No
Which side? _____ Right; _____ Left; _____ Both; _____ Middle

0 1 2 3 4 5 6 7 8 9 10

no pain extreme pain

19. Have you ever been in an accident or received a blow or injury to any part of your face, head, neck or back?
_____ Yes _____ No If yes, explain

20. Are you aware of your jaw making sounds? _____ Yes _____ No_____Right_____Left
If yes, describe the nature of the sound:
_____ Clicking _____ Popping
_____ Grating _____ Cracking
Other _____

If yes, when do you notice the sound?
_____ Early opening _____ Moving jaw to the side
_____ Middle opening _____ Chewing
_____ Wide opening _____ While closing

If yes, is the sound always present? _____ Yes _____ No
If yes, is there pain associated with the sound? _____ Yes _____ No _____ Sometimes

21. Has your jaw ever locked open? _____ Yes _____ No
_____ Right side; _____ Left side; _____ Both sides
Date of first occurrence _____
If so, can you replace the jaw to normal position yourself? _____ Yes _____ No

22. Has your jaw ever locked closed or partially closed? _____ Yes _____ No
Which side? _____ Right; _____ Left; _____ Both sides

23. How many times has your jaw locked open or closed during the past year? ____
24. Is there pain when your jaw locks open or closed? _____ Yes _____ No

25. When you open your mouth, does something in your jaw joint feel like it is in the way?
_____ Yes _____ No
Which side? _____ Right; _____ Left; _____ Both sides

26. Do you need to move your jaw from side to side or forward to enable you to open or close your mouth? _____ Yes _____ No
Which side? _____ Right; _____ Left; _____ Both sides

27. What foods do you avoid eating because of this problem?
_____ Hard foods _____ Chewy foods _____ None
Other _____

28. On which side of your mouth do you do most of your chewing?
_____ Right side _____ Left side _____ Can't tell

29. Do you have pain when you chew? _____ Yes _____ No
Which side? _____ Right _____ Left _____ Both sides
Using the rating scale indicate the severity of the pain you are experiencing by circling the appropriate area:

0 1 2 3 4 5 6 7 8 9 10

no pain extreme pain

30. Have you ever had braces on your teeth?
_____ Yes _____ No If yes, when?

31. Do you chew gum? _____ Yes _____ No; If yes, how much?
_____ 0-5% of waking hours
_____ 5-15% of waking hours
_____ 15-25% of waking hours
_____ 25-50% of waking hours
_____ 75-100% of waking hours

32. Do you have any other oral habits or practices that may aggravate or cause pain?
_____ Yes _____ No If yes, what? _____
_____

33. Do you clench your teeth? _____ Yes _____ No
When? _____ Under tension _____ While sleeping Other

34. Do you grind your teeth? _____ Yes _____ No
When? _____ Under tension _____ While sleeping _____Other

If other, please explain_____
_____

35. Do you feel that clenching or grinding your teeth causes or contributes to your pain?
_____ Yes _____ No _____ Sometimes

36. Do you feel that you are under stress much of the time?
_____ Yes _____ No _____ Occasionally

37. Does increased stress seem to make the pain problem worse?
_____ Yes _____ No _____ Occasionally

38. Do you sleep well? _____ Yes _____ No _____ The pain problem is effecting my sleep.

How many hrs of sleep do you get a night?___
Do you feel you're getting enough sleep?____Yes ____No

39. Do you awaken frequently during the night? _____ Yes _____ No

40. Do you go to bed more tired than your daily activities justify? _____ Yes _____ No

41. Do you feel rested when you get up in the morning? _____ Yes _____ No

42. How many pillows do you sleep on? _____

43. Do you snore?_____Yes _____No

44. Do you choke when you snore? _____Yes _____No

45. Have you been diagnosed with sleep apnea? _____Yes _____No
Do you feel you may have sleep apnea? _____Yes _____No

46. Are you stiff or sore when you wake up in the morning? _____ Yes _____ No
Do you sleep on your stomach? _____Yes No

47. Do you wake up with a headache? _____ Yes _____ No

48. Do you have headaches later in the day? _____ Yes _____ No

49. Do you have more than one type of headache? _____ Yes _____ No
If yes, please list them:_____
_____
_____

50. Do you have headaches as often as once per week? _____ Yes _____ No
If yes, how many per week? _____

51. Is there any nausea or vomiting associated with your headaches? _____ Yes _____ No
If yes, how many per week? _____

52. Are there vision changes associated with your headaches? _____ Yes _____ No;
If yes, what kind? _____
_____

53. Do you take medication for the headache pain? _____ Yes _____ No
If yes, what? _____
_____
_____

54. What relieves the headache?
_____ Pain medication
_____ Rest
_____ Sleep
_____ Exercise
Other _____

55. Do you tire or fatigue easily? _____ Yes _____ No

56. For each of the beverages listed below, write in the average number you drink each day:
Caffeinated coffee _____ cups/day
Decaffeinated coffee _____ cups/day
Tea _____ cups/day
Carbonated soft drinks _____ cans or bottles/day

57. Do you feel that you usually eat a healthful, balanced diet? _____ Yes _____ No

58. Do you get any type of regular exercise? _____ Yes _____ No;
If yes, what kind? _____

59. Do you enjoy your job? _____ Yes _____ No

60. Stress Factors (Please circle each factor that applies to you)

Death of spouse	Major illness or injury	Major health change in family
Business adjustment	Divorce	Pending marriage
Financial problems	Pregnancy	Career Change
Fired from work	Marital reconciliation	Taking of debt
Death of a family member	New person joins family	Other
Marital separation		

61. Are you presently, or have you ever been under the care of psychiatrist or a psychologist?
_____ Yes _____ No

62. List any activity that holds the head or jaw in an imbalanced position. (Phone, swimming, instrument, etc.)
Describe: _____

63. Do you play video games? _____Yes _____No If yes, how many hours a week?_____

64. What types of health care providers have you seem for your problem?

[ ]None	[ ]Rheumatologist	[ ]General Dentist
[ ]Rehabilitation medicine	[ ]Physical Medicine	[ ] Oral Surgeon
[ ]Pain Clinic	[ ]Anesthesiologist	[ ] Orthodontist
[ ]TMJ Specialist	[ ]Family Physician	[ ]Ophthalmologist
[ ]Internist	[ ]Osteopathis Physician	[ ]Chiropractor
[ ]Ear, Nose, Throat physician	[ ]Neurologist	[ ] Neurosurgeon
[ ]Orthopedic Surgeon	[ ]Physical Therapist	[ ]Other

If other, Please describe_____

_____

_____

_____

65. Please list the names of the above health care providers:

_____

_____

_____

_____

66. Which of the following treatment(s) have you received for your pain:

[ ]Traction	[ ]Hypnosis	[ ]Drug/Alcohol Rehab
[ ]Injections	[ ]Splint/bite plates	[ ]Chiropractic Treatment
[ ]Acupuncture	[ ]Counseling	[ ]Electrical Stimulation
[ ]Massage	[ ]Medications	[ ]Ultrasound or Lontophoresis
[ ]Nerve blocks	[ ]Heat/Cold applications	[ ]Root canal/dental treatment
[ ]Biofeedback	[ ]Acupressure	[ ]Exercise
[ ]Pain Program	[ ]Stress management	[ ]Occlusal/Bite Adjustment
[ ]TMJ Surgery	[ ] Orthodontics/Braces	[ ]Other

If other, Please describe_____

_____

_____

_____

67. Which tests have you had for the problem?

[ ]X-rays	[ ]Myelogram	[ ]Tooth pulp test
[ ]TMJ X-ray	[ ]Venogram	[ ] Urine studies
[ ]TMJ MRI	[ ]Arteriogram	[ ] Blood studies
[ ]Cone Beam CT Scan	[ ]Thermogram	[ ]diet analysis
[ ]Brain MRI	[ ]Salivary gland studies	[ ]Nerve block
[ ]CT Scan	[ ]Salivary flow studies	[ ]EMG
[ ]Other		

GENERAL MEDICAL HISTORY

1. Have you been to see a physician within the past 2 years? _____ Yes _____ No; if yes, for what problem?

2. Please give the name and address of your regular physician:

_____

_____

3. Circle any of the following that you have had or have at present:

Heart Failure
Heart Disease or Heart Attack
Angina Pectoris
High Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart problems

Artificial Heart Valves
Heart Pacemaker

Heart Surgery

Artificial Joint
Anemia

Stroke
Kidney Trouble

Stomach Ulcers

Colitis
Persistent Diarrhea

Chronic Cough
Tuberculosis (TB)

Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes

Thyroid Disease

X-ray or Cobalt Treatment
Chemotherapy (Cancer, Leukemia)
Arthritis
Cortisone Medicine

Glaucoma
AIDS

White or Blue Patches in Mouth
Emphysema
Enlarged Glands
Lymph Nodes

Hepatitis
Liver Disease

Yellow Jaundice
Blood Transfusion
Drug Addiction
Hemophilia
Venereal Disease (Syphilis, Gonorrhea, Chlamydia)

Genital Herpes

Cold Sores or Fever Blisters
Epilepsy or Seizures
Fainting or Dizzy Spells
Depression
Nervousness or Anxiety
Psychiatric Treatment

Sickle Cell Disease

4. Have you been a patient in the hospital two years? _____ Yes _____ No
   If yes, for what problem? _____

5. Have you ever had any operations or surgery? _____ Yes _____ No
   If yes, what was the problem? _____

6. Have you ever had any excessive bleeding requiring special treatment?
   _____ Yes _____ No

7. Are you taking any medicines, drugs, or pills of any kind? _____ Yes _____ No

If yes, What are the medications and dosages? _____
_____
_____
_____

8. Do you have any allergies to drugs or medicines? _____ Yes _____ No
   If yes, to what and how do you react? _____

9. Have you ever had an unusual reaction to a dental anesthetic? _____ Yes _____ No

10. When you walk up stairs or take a walk, do you ever have to stop because you are very tired?
    _____ Yes _____ No

11. Do your ankles swell during the day? _____ Yes _____ No

12. Do you sleep on more than two pillows? _____ Yes _____ No

13. Do you ever wake up from sleep short of breath? _____ Yes _____ No

14. Have you unintentionally lost or gained more than 10 pounds in the past year?
    _____ Yes _____ No

15. Are you on a special diet? _____ Yes _____ No

16. Has your medical doctor ever said you had a cancer or tumor? _____ Yes _____ No

17. Do you have any disease, condition, or problem not listed? _____ Yes _____ No

18. WOMEN: Are you pregnant now? _____ Yes _____ No
    Are you practicing birth control? _____ Yes _____ No
    Do you anticipate becoming pregnant? _____ Yes _____ No