**Patient Name:**______________________________ **Date:**_____________

1. Please give us the FIRST TIME you noticed a problem with your Pain in the Orofacial Area or problems with function of the Jaw or TMJ. Month and year. _______________

2. List IN ORDER OF IMPORTANCE all of the problems or symptoms which trouble you. Be as brief as possible in describing them.
#1 ________________________________________________________________
#2 ________________________________________________________________
#3 ________________________________________________________________
#4 ________________________________________________________________

3. Have you received any prior treatment or evaluation for this problem? Describe briefly.
Doctor:____________________Treatment(s):________________Results:__________________
Doctor:____________________Treatment(s):________________Results:__________________
Doctor:____________________Treatment(s):________________Results:__________________

4. Have you had a JAW INJURY that could have caused your TMJ pain/problem?
Yes:___No:___. If yes, please list the date of the injury(s) and describe. Injury
Date:_______________ Type of Injury:____________________________________________

5. If yes, please rate now much your JAW INJURY contributed to the cause of your TMJ pain/problem by placing a slash (/) somewhere on the line below.
|______________________________________________________________|
No relationship — Main cause of problem

6. Are you receiving any COMPENSATION or DISABILITY for your TMJ problem?
Yes:___No:___. If yes, describe:____________________________________________________

7. Are you currently in the process of LITIGATION related to your TMJ problem?
Yes:___No:___. If yes describe:______________________________________________________

8. Place a slash (/) somewhere along the scale below and number it to indicate the intensity of your USUAL PAIN LAST WEEK by placing a slash (/) somewhere on the line below.
|______________________________________________________________|
No pain — Most severe pain imaginable

9. Rate how much pain you are experiencing RIGHT NOW at this moment by placing a slash (/) somewhere on the line below.
|______________________________________________________________|
No pain — Most severe pain imaginable

10. Please rate how much your TMJ pain/problem INTERFERES with your DAILY ROUTINE or activities of normal living by placing a slash (/) somewhere on the line below.
|______________________________________________________________|
No interference — Completely interferes

**Patient Name:________________________________** **Date:______________**

11. Please rate how much your TMJ pain/problem DISTURBS your SLEEP. Please CIRCLE the appropriate number below.

|__________________________________________________________|

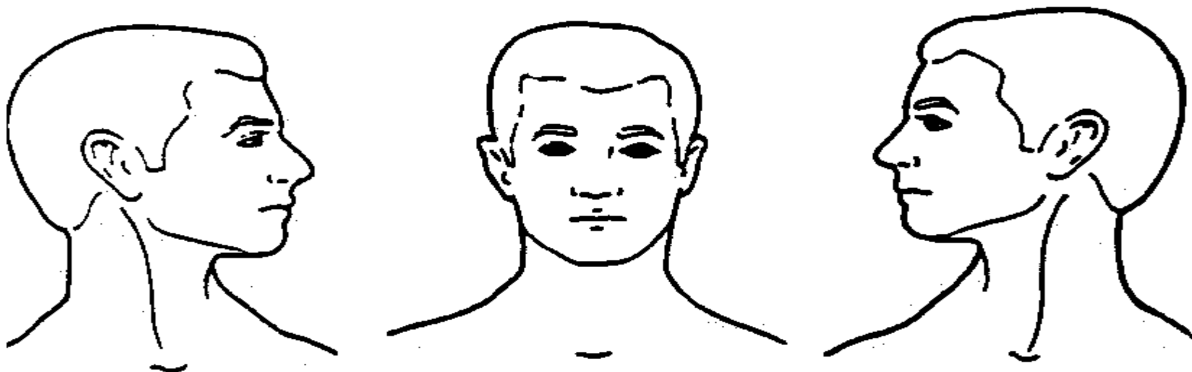
0 1 2 3 4 5 6 7 8 9 10

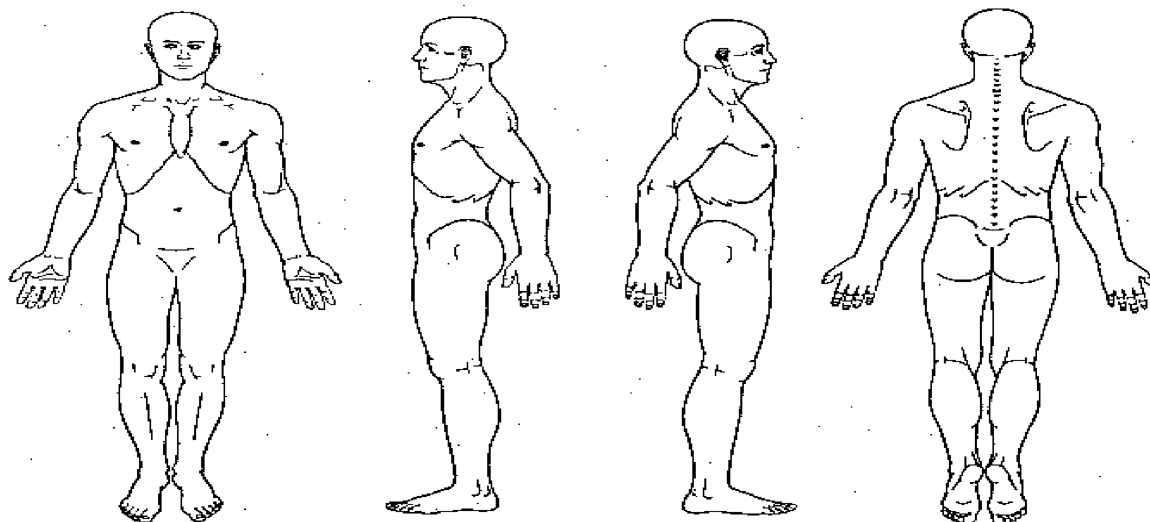
No Interference — Completely Prevents Sleep

12. Time of Pain: Rate the USUAL INTENSITY of your pain with a slash (/) along the scales below at the following periods throughout the day:

| | No pain | Most intense pain imaginable |
|---|---|---|
| Morn. | \|____________________________________________________\| | |
| Noon | \|____________________________________________________\| | |
| Afternoon | \|____________________________________________________\| | |
| Evening | \|____________________________________________________\| | |
| Sleep | \|____________________________________________________\| | |

On the diagrams below, please CIRCLE those areas in where you currently have pain.





Patient Name____________________________ Date:___________________

# OROFACIAL PAIN AND TMD QUESTIONNAIRE

INSTRUCTIONS: Please check the appropriate answer to the following questions.

| **A. Jaw Pain Questions** | Doesn't Hurt At All. (0) | Hurts A Little. (1) | Hurts A Lot. (2) | Almost Unbearable. (3) | Unbearable Pain Without Relief. (4) |
|---|---|---|---|---|---|
| 1. Does it hurt when you open wide or yawn? | _____ | _____ | _____ | _____ | _____ |
| 2. Does it hurt when you chew, or use the jaws? | _____ | _____ | _____ | _____ | _____ |
| 3. Does it hurt when you are not chewing or using the jaws? | _____ | _____ | _____ | _____ | _____ |
| 4. Is your pain worse on waking? | _____ | _____ | _____ | _____ | _____ |
| 5. Do you have pain in front of the ears or ear aches? | _____ | _____ | _____ | _____ | _____ |
| 6. Do you have jaw muscle (cheek) pain? | _____ | _____ | _____ | _____ | _____ |
| 7. Do you have pain in the temples? | _____ | _____ | _____ | _____ | _____ |
| 8. Do you have pain or soreness in the teeth? | _____ | _____ | _____ | _____ | _____ |

| **B. Jaw Function Questions** | No (0) | Maybe A Little (1) | Quite A lot (2) | Almost All The Time (3) | All the Time Without Stopping (4) |
|---|---|---|---|---|---|
| 1. Do your jaw joints make noise so that it bothers you or others? | _____ | _____ | _____ | _____ | _____ |
| 2. Do you find it difficult to open your mouth wide? | _____ | _____ | _____ | _____ | _____ |
| 3. Does your jaw ever lock closed so you cannot open it? | _____ | _____ | _____ | _____ | _____ |
| 4. Does your jaw ever lock open so you cannot close it? | _____ | _____ | _____ | _____ | _____ |
| 5. Do you have a problem with your bite being uncomfortable? | _____ | _____ | _____ | _____ | _____ |

Patient Name___________________________ Date:__________________

**C. Headache, Habits and Disability Questionnaire**

| | Never (0) | Some-times (1) | Often (2) | All the Time (3) |
|---|---|---|---|---|
| 1. Do you have pain in the mouth or in a tooth area? | _____ | _____ | _____ | _____ |
| 2. Do you have neck or shoulder pain? | _____ | _____ | _____ | _____ |
| 3. Do you have headaches? | _____ | _____ | _____ | _____ |
| 4. Do you have sharp stabbing pain in the face? | _____ | _____ | _____ | _____ |
| 5. Do you clench or grind your teeth during the day? | _____ | _____ | _____ | _____ |
| 6. Do you clench or grind your teeth during sleep? | _____ | _____ | _____ | _____ |
| 7. Do your symptoms worsen with stress, anger, anxiety, frustration, or driving? | _____ | _____ | _____ | _____ |
| 8. Do you have gastritis (stomach pain), colitis or other digestive track problems? | _____ | _____ | _____ | _____ |
| 9. Do you have arthritis or other sore joints? | _____ | _____ | _____ | _____ |
| 10. Do you associate any dizziness, numbness, visual, sweating or other unusual effects with your problem or pain? | _____ | _____ | _____ | _____ |
| 11. Do you currently suffer from nausea and/or vomiting when you have headaches? | _____ | _____ | _____ | _____ |
| 12. How much does your pain/problem effect at work? | _____ | _____ | _____ | _____ |
| 13. How much does your pain/problem effect social/family relationships? | _____ | _____ | _____ | _____ |
| 14. Are you depressed as a result of the pain/problem? | _____ | _____ | _____ | _____ |