HEAD AND NECK PAIN CONTROL CENTER

TMJ / PAIN HEADACHE QUESTIONAIRRE

Date______________________

Please answer all questions so that we may be able to manage your problem.

Name____DOB__________Sex________Marital Status________

Addrerss____State___________________Zip________________

Phone(______)______________________________ Work(_____)________________________________

Occupation____SSN_______________________________________

How did you hear about Dr. Brown or who referred you to Dr. Brown?______________________________________

1. My last medical examination was on____

   Physician's Name / Address / Phone #____

   ____

2. My last dental examination was on____

   Dentist's Name / Address / Phone #____

   ____

3. List in chronological order the Dentists and Physicians who have treated you for your pain problem.

   (Names / Addresses)

   ____

   ____

   ____

   ____

4. Have you ever been hospitalized for any serious illness or operation? _____Yes _____No

   If yes, please explain with dates____

   ____

   ____

   ____

5. Do you regularly take any medication or pills? _____Yes _____No

   If yes, please explain with dates and dosages if possible____

   ____

   ____

6. Do you have any allergies? (environmental or drugs?) _____Yes _____No

   If yes, please explain____

   ____

   Iodine or IVP Dye _____Yes _____No

7. Have you ever had a bad reaction to medication other than allergic in nature? _____Yes _____No

   If yes, Please explain____

   ____

8. Have you ever been treated for any mental or emotional problems? _____Yes _____No

   If yes, please explain with dates ____

   ____

9. Have you ever experienced numbness of one side of the face or body? _____Yes _____No

10. Do you suffer from chronic headache? _____Yes _____No Ear Pain? _____Yes _____No

    Ear Infections? _____Yes _____No

11. Do you suffer from stomach trouble or ulcer? _____Yes _____No

12. Are you suffering from rheumatism or arthritis? _____Yes _____No

    What type? _____Rheumatiod _____Degenerative _____Traumatic _____Gout

13. Do your muscles and joints ever feel stiff or swollen? _____Yes _____No

14. Do you ever experience muscle aches or spasms? _____Yes _____No If so, where?_________________

    ____

15. Do you have trouble sleeping? _____Yes _____No Use sleeping pills? _____Yes _____No

16. Do you suffer from low back pain? _____Yes _____No

17. Do you have any eye problems? _____Yes _____No Wear glasses? _____Yes _____No

    Surgery? _____Yes _____No Blurred vision? _____Yes _____No Double vision? _____Yes _____No

    Spots? _____Yes _____No Pain behind the eyes? _____Yes _____No

18. Do you have sinus problems? _____Yes _____No

19. Do your salivary glands ever hurt or swell? _____Yes _____No

20. Have you ever had dental pain or infection? _____Yes _____No

21. Have you had your wisdom teeth removed? _____Yes _____No

22. Difficulty swallowing? _____Yes _____No Painful? _____Yes _____No

23. When did your problem with pain (TMJ, Face, Head, Neck) begin? (Please use dates if possible)________

    ____

24. How long has this problem persisted?____

Have there been periods of remission? _____Yes _____No

25. What part of the day is the pain or functional problem most severe?________________________________

26. Please check all symptoms that apply to you:

_____Ear Pain
_____Face Pain
_____Neck Pain
_____Eye Pain or Burning
_____Uncomfortable Dental Bite
_____Hearing Problems
_____One-sided Headaches
_____Sore / Sensitive Teeth
_____Dizziness / Loss of Balance
_____Ringing in the Ears

27. Is this pain:

_____Constant
_____Aching
_____Stabbing
_____Burning
_____Shooting
_____Worse in the Morning
_____Worse in the Afternoon
_____Awakens You at Night
_____When Chewing
_____Electrical

28. Does your Jaw:

_____Click or Pop
_____Catch or "Hang-up"
_____Make a Grinding Noise
_____Lock Open
_____Lock Closed
_____Deviate to One Side

29. If none of these symptoms are occurring now, have any of these symptoms occurred in the past?

_____Yes _____No Please explain____

____

____

30. Have you ever been involved in an accident or had a sports injury? _____Yes _____No

If yes, please explain____

____

Any injury to the head and neck? _____Yes _____No Whiplash? _____Yes _____No

31. Do you have any oral habits such as grinding or clenching your teeth? _____Yes _____No

Cheek or lip biting? _____Yes _____No

Biting on hard objects or ice? _____Yes _____No

32. Have you ever had orthodontics? (braces) _____Yes _____No If so, when?______________________

How long?__________________________ Retainer?____

Was there any relationship to onset of pain to cessation of braces? ______________________________

33. Have you ever had jaw surgery for deformity? _____Yes _____No

Fracture? _____Yes _____No Please explain:____

____

34. Have you had any treatment for your problem?

_____ Bite Splint

_____ Medication

_____ Physical Therapy

_____ Counseling

_____ Dental Bite Adjustment

_____ Orthodontics

_____ Surgery

_____ Other________________________________

35. Are you frequently confined to bed by illness? _____Yes _____No

36. Are you always in poor health? _____Yes _____No

37. Do you come from a sickly family? _____Yes _____No

38. Has pain made it impossible for you to work? _____Yes _____No

39. Are you constantly made miserable by poor health? _____Yes _____No

40. Do you have to lie down and rest often because of pain? _____Yes _____No

41. Does pain bother you so much you have to keep moving? _____Yes _____No

42. Has pain interfered with your sex life? _____Yes _____No

43. Are you unable to do all the things you want to because of pain? _____Yes _____No

44. Do you find that all you can think about is your pain? _____Yes _____No

45. Do doctors seem to have failed you? _____Yes _____No

46. Do you keep looking for a specialist to solve your case? _____Yes _____No

47. Do you have trouble getting doctors to take you seriously? _____Yes _____No

48. Have some doctors said your pain was imaginary? _____Yes _____No

49. Do you secretly think your case may be hopeless? _____Yes _____No

50. On a scale of 1 through 10, where would your pain fall in severity?________________________________

51. Describe your problem in your own words:____

____

____

____

52. Draw an outline and shade the area of your pain: