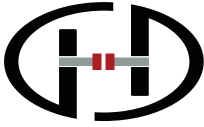


Pain Questionnaire

Revised 7/2023

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? ____________________

3. Describe in order (first to last), what you expect from treatment. _________________

____

____

____

4. 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

5. Have you ever been examined for a TMD problem before? _____Yes _____ No

If yes by whom & when? ____
____
____

6. 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

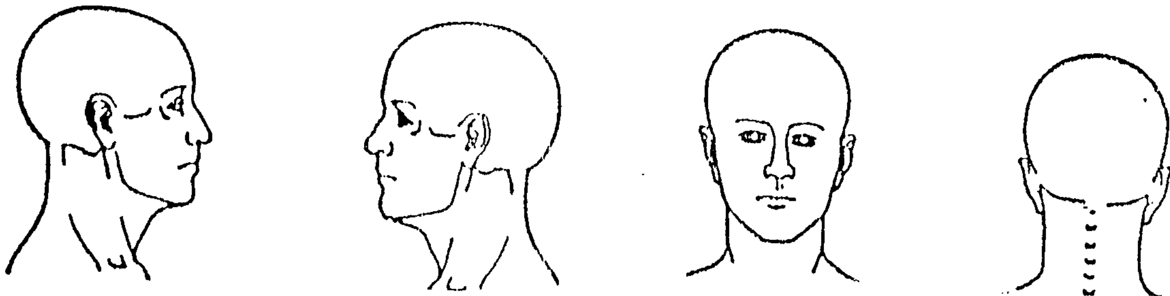
   no pain extreme pain

7. Describe the pain:

   _____ Dull _____ Aching _____ Burning
   _____ Throbbing _____ Pressure _____ Pulsating
   _____ Stabbing _____ Sharp _____ Punishing/Cruel
   _____Tiring/Exhausting _____Sickening ______Other________________________

8. 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

9. On the diagrams please circle the areas where you have pain:



10. How long have you had this pain?
    What happened for the pain to start then? ______________________________________
    Number of : _____ years; _____ months; _____ weeks

11. When do you have pain?
    _____ Constantly
    _____ Frequently but not predictable
    _____ Frequently and predictably

_____ Occasionally
_____ No real pattern

12. 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 ____

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

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

If yes, please explain____

15. Do any of the following cause or aggravate the pain?
_____ Chewing   _____ Yawning   _____Lack of sleep
_____ Opening mouth wide   _____ Laughing   _____ Exercise
_____ Talking   _____ Singing   _____ Eating certain foods
_____ Playing a musical instrument   _____ Stress/emotional upset
_____ Sitting for a long periods of time   _____Other ________________________________

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

17. Check any of the following that you experience.

[ ] Numbness in the face or jaw   [ ] Weakness in jaw muscles
[ ] Earache   [ ] Ringing or buzzing in the ears
[ ] Ear stuffiness   [ ] Dizziness
[ ] Easily fatigued   [ ] Pain in the back of the head
[ ] Aches and pains all over body   [ ] Morning stiffness
[ ] Unusual tastes   [ ] Jaw catching

[ ] Change in ability to taste [ ] Decreased ability to open mouth
[ ] Numbness/tingling in hands or fingers

18. Do you have pain in the cheek? _______Yes _______No
If yes, 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

19. Do you have pain the temple or above the ear?
_____ Yes _____ No
If yes, 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

20. 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

21. 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

22. Have you ever been in an accident or received a blow or injury to any parts of your

face, head, neck or back? _____ Yes _____ No
If yes, please explain:____
____

23. Are you aware of your jaw making sounds? _____ No _____ Yes

IF YES, WHICH SIDE: _____Right _____ Left _____ Both sides

If yes describe 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 sounds? _____ Yes _____ No _____ Sometimes

24. 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
Has your jaw ever locked closed or partially closed? _____ Yes _____ No
Which side? _____ Right _____ Left _____ Both sides

25. How many times has your jaw locked open or closed during the past year? ________

26. Is there pain when your jaw locks open or closed? _____ Yes _____ No

27. 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

28. 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

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

30. On which side of your mouth do you do most of your chewing?

_____ Right side _____ Left side _____ Can't tell

31. 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

32. Have you ever had braces on your teeth?
_____ Yes _____ No

If yes, when and by whom? ____

33. 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

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

35. Do you clench your teeth? _____ Yes ______ No
When? Under tension _____ While sleeping _____
If other, please explain ____

36. Do you grind your teeth? _____ Yes _____ No
When? Under tension _____ While sleeping _____
If other, please explain ____

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

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

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

40. Do you sleep well? _____ Yes _____ No _____ The pain problem is affecting my sleep

How many hours of sleep do you get a night? ______

Do you feel you’re getting enough sleep? _____ Yes _____ No

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

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

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

44. How many pillows do you sleep on? _________

45. Do you snore? _______Yes _______No

46. Do you choke when you snore? _____Yes _____No

47. Have you been diagnosed with sleep apnea? _____Yes _____No
    Do you feel you may have sleep apnea? _____ Yes _____ No

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

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

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

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

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

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

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

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

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

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

57. 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

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

59. Do you get any type of regular exercise? _____ Yes _____ No

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

61. 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		

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

63. List any activity, which holds the head or jaw in an imbalanced position. (Phone, swimming, instrument)
Describe: ____

64. Do you play video/ phone/ tablet games? ______Yes ______No
If yes, how many hours a week?_______

65. What types of health care providers have you seen 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____
____
____

66. Please list the names of the above health care providers:
____
____

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

[ ] Traction
[ ] Injections
[ ]Acupuncture
[ ]Massage
[ ]INerve blocks
[ ]Biofeedback
[ ]Pain program
[ ] TMJ Surgery
[ ] Other
[ ]Hypnosis
[ ] Splint/bite plate
[ ] Counseling
[ ]Medication
[ ] Heat/Cold applications
[ ] Acupressure
[ ] Stress management
[ ] Orthodontics/Braces
[ ] Drug Rehab
[ ] Alcohol Rehab
[ ] Chiropractic care
[ ] Electrical Stimulation
[ ] Ultrasound/lontophoresis
[ ] Root canal/dental treatment
[ ] Exercise
[ ]Occlusal/bite adjustment

If other, please describe____
____
____
____

How did this treatment(s) help/affect you? ____
____
____
____

68. Which tests have you had for the problem?

[ ] Xrays
[ ] TMJ Xray
[ ]TMJ MRI
[ ]Cone beam CT Scan
[ ]Brain MRI
[ ]CT Scan
[ ]Other
[ ]Myelogram
[ ] Venogram
[ ] Arteriogram
[ ] Thermogram
[ ] Salivary gland studies
[ ] Salivary flow studies
[ ] Tooth pulp test
[ ] Urine studies
[ ] Blood studies
[ ] Diet analysis
[ ] Nerve block
[ ] EMG

If other, please describe____
____
____
____

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, which 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

Chronic Cough
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes
Emphysema
Thyroid Disease
X-ray or Cobalt Treatment
Chemotherapy (Cancer, Leukemia)
Arthritis
Cortisone Medicine
Glaucoma
AIDS
White or Blue Patches in Mouth

Hepatitis
Liver Disease
Yellow Jaundice
Blood Transfusion
Drug Addiction
Hemophilia
Venereal Disease (Syphilis, Gonorrhea, Chlamydia)
Persistent Diarrhea
Genital Herpes
Enlarged Glands Lymph nodes
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 in the past two years? ____ Yes ____ No
If yes, for what problem? ____
____

5. Have you ever had any operations or surgery? ____ Yes ____ No
If yes, for what? ____
____

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

7. Are you taking any medicines, drugs, or pills of any kinds? ____ Yes ____ No

If yes, what are the medications and the dosages? ______________________________________
____
____
____

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

9. Have you ever had an usual reaction to 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 ever wake up from sleep short of breath? ____ Yes ____ No

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

14. Are you on a special diet? ____ Yes ____ No

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

16. Do you have any diseases, conditions, or other problems not listed? ____ Yes ____ No
If yes, please explain ____
____

17. **WOMEN**: Are you pregnant now? ____ Yes ____ No

Are you practicing birth control? ____ Yes ____ No

Do you anticipate becoming pregnant? ____ Yes ____ No