Pain Questionnaire

Revised 3/2024

PATIENT NEEDS TO FILL FORM OUT UNLESS HE/SHE DOES NOT UNDERSTAND! PLEASE USE BLACK INK!

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:

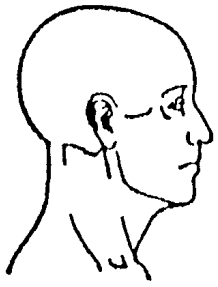
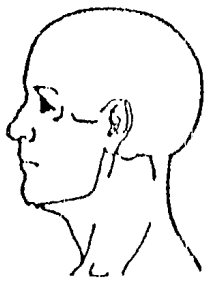
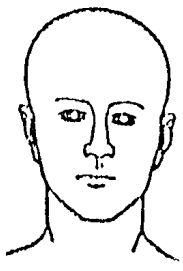
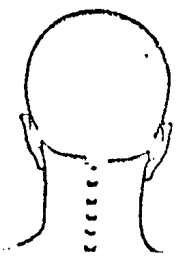
0	1	2	3	4	5	6	7	8	9	10
no pain										extreme pain

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
_____ 1-10 minutes
_____ Less than 1 hour
_____ 1-5 hours
_____ 6-12 hours
_____ 13-24 hours
_____ Several days
_____ 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
_____ Opening mouth wide
_____ Talking
_____ Playing a musical instrument
_____ Sitting for a long periods of time
_____ Yawning
_____ Laughing
_____ Singing
_____ Stress/emotional upset
_____Other _____
_____Lack of sleep
_____ Exercise
_____ Eating certain foods

16. What relieves the pain?
_____ Massage of the area
_____ Warm soaks or compresses
_____ Holding jaw in certain positions
_____ Pain medication
_____ Moving or manipulating jaw
_____ Sleep
_____ Time
_____ Relaxation
_____ Heat
_____ 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 a car accident? _____Yes _____No
If yes, please explain: _____
Have you ever had a concussion? _____Yes _____No
If yes, please explain: _____
Have you ever had stitches in the head or neck area? _____Yes _____No
If yes, please explain: _____
Have you had surgery with a general anesthetic? _____Yes _____No
If yes, please explain: _____
Have you ever had surgery with a breathing tube? _____Yes _____No
If yes, please explain: _____
Have you had tonsils and/or adenoids removed? _____Yes _____No
If yes, please explain: _____
Have you had wisdom teeth removed? _____Yes _____No
If yes, please explain: _____
Did you participate in contact sports in high school or college? _____Yes _____No
If yes, please explain: _____
Do you participate in contact sports now? _____Yes _____No
If yes, please explain: _____
Have you had any facial trauma? _____Yes _____No
If yes, please explain: _____
Do you recall or know of any falls on your face before you were 10 years old? _____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 _____ 25-50% of waking hours
_____ 5-15% of waking hours _____ 75-100% of waking hours
_____ 15-25% 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? _____

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

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

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

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

58. 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

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

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

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

62. 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		

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

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

65. Do you play video/ phone/ tablet games? _____Yes _____No
If yes, how many hours a week?_____

66. 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_____
_____
_____

67. Please list the names of the above health care providers:
_____
_____

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

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

If other, please describe_____

_____

_____

_____

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

_____

_____

_____

69. Which tests have you had for the problem?

[ ] Xrays	[ ]Myelogram	[ ] Tooth pulp test
[ ] TMJ Xray	[ ] 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		

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	Chronic Cough	Hepatitis
Heart Disease or Heart Attack	Tuberculosis (TB)	Liver Disease
Angina Pectoris	Asthma	Yellow Jaundice
High Blood Pressure	Hay Fever	Blood Transfusion
Heart Murmur	Sinus Trouble	Drug Addiction
Rheumatic Fever	Allergies or Hives	Hemophilia
Congenital Heart Problems	Diabetes	Venereal Disease
	Emphysema	(Syphilis, Gonorrhea, Chlamydia)
Artificial Heart Valves	Thyroid Disease	Persistent Diarrhea
Heart Pacemaker	X-ray or Cobalt	Genital Herpes
	Treatment	Enlarged Glands Lymph nodes
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Cold Sores or Fever Blisters
Artificial Joint	Arthritis	Epilepsy or Seizures
Anemia	Cortisone Medicine	Fainting or Dizzy Spells
Stroke	Glaucoma	Depression
Kidney Trouble	AIDS	Nervousness or Anxiety
Stomach Ulcers	White or Blue Patches in Mouth	Psychiatric Treatment
Colitis		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 unusual 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