PAIN QUESTIONNAIRE

PLEASE USE BLACK INK!
Patient needs to fill out form- not the parent/guardian.

*****Bring this to the office BEFORE your appointment so the information can be addressed. If we receive it at the appointment, we will schedule an appointment to come back and discuss this information. It can take 30-60 minutes just to discuss the questionnaire appropriately.*****

Date: _____/_____/_____
Patient Full Name: _____
Address _____
Telephone no._____-_____-_____
City _____State _____ Zip _____
Age _____ Biological/Genetic Sex: Male _____ Female _____
Marital status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widow/widower
Number of children _____ ages _____
Current Occupation:_____
Physician Name: _____
Dentist Name: _____
Who referred you to our office: _____
Address and phone (if not in Decatur area): _____

1. What problem(s) brings you to our office?_____

2. What do you think caused you to have pain? _____

3. Describe in order (first to last), what you expect from orthodontic 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
What is the severity of the pain you are experiencing? Circle the appropriate number:
no pain 0 1 2 3 4 5 6 7 8 9 10 extreme pain

7. Describe the pain:

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

8. Does the pain radiate, travel, or move from the area of initial pain?

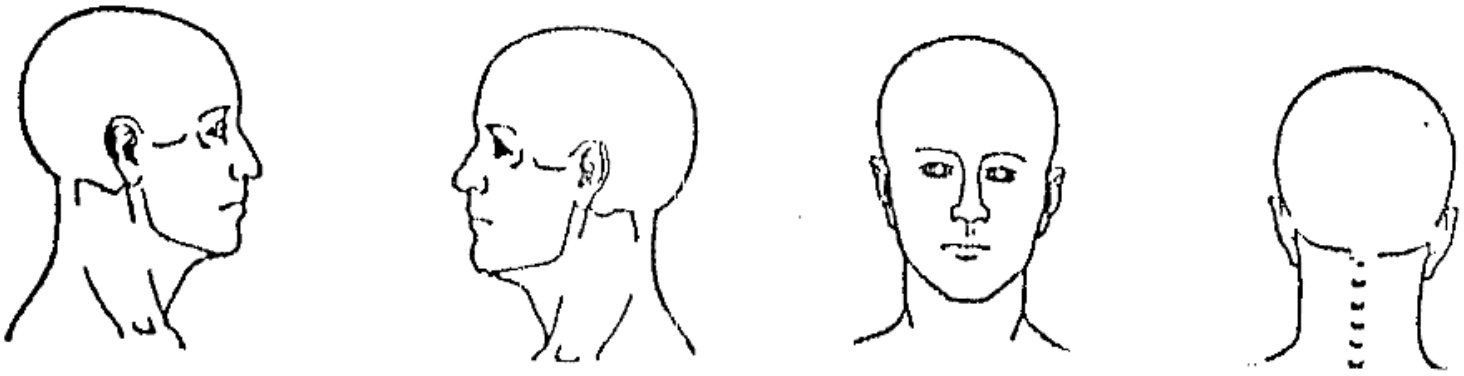
_____ Yes _____ No

_____ 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? _____ years; _____ months; _____ weeks

When the pain started, what happened around that time?_____

11. When do you have pain?

_____ Constantly _____ Frequently and predictably _____ Frequently, but not predictable

_____ Occasionally _____ No real pattern

12. Is there a pattern to your pain? _____Yes ____No

If yes, please check all options when your pain occurs.

_____Work &/or School Days _____Mostly Day/Mostly Evening _____Hormonally related

Other _____

13. How long does the pain last?

_____ Less than 1 minute _____ Less than 1 hour _____ 6-12 hours _____ Several days

_____ 1-15 minutes _____ 1-5 hours _____ 13-24 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 _____ Pain medication _____ Sleep

_____ Warm soaks or compresses _____ Time _____ Relaxation

_____ Holding jaw in certain positions _____ Moving or manipulating jaw _____ Heat

_____ Ice/Cold Compresses _____ Other _____

17. Check any of the following that you experience.

___Numbness in the face or jaw
___Earache or stuffiness
___Numbness/tingling in hands or fingers
___Easily fatigued
___Aches and pains all over body
___Unusual tastes
___Change in ability to taste
___Weakness in jaw muscles
___Ringing or buzzing in the ears
___Dizziness
___Pain in the back of the head
___Morning stiffness
___Jaw catching
___Decreased ability to open mouth

18. Do you have pain in the cheek/jaw? _____Yes _____No
If yes, which side? _____ Right_____ Left _____ Both sides
What is the severity of the pain you are experiencing? Circle the appropriate number:
no pain 0 1 2 3 4 5 6 7 8 9 10 extreme pain

19. Do you have pain the temple or above the ear? _____ Yes _____ No
If yes, which side? _____ Right_____ Left _____ Both sides
What is the severity of the pain you are experiencing? Circle the appropriate number:
no pain 0 1 2 3 4 5 6 7 8 9 10 extreme pain

20. Do you have pain in your neck? _____ Yes _____ No
What is the severity of the pain you are experiencing? Circle the appropriate number:
no pain 0 1 2 3 4 5 6 7 8 9 10 extreme pain

21. Do you have pain in your back? _____ Yes _____ No
Which side? _____ Right; _____ Left; _____ Both; _____ Middle
What is the severity of the pain you are experiencing? Circle the appropriate number:
no pain 0 1 2 3 4 5 6 7 8 9 10 extreme pain

22. Have you experienced: (Read all parts of this question.)
Car accident? _____Yes _____No
If yes, please explain: _____
Concussion? _____Yes _____No
If yes, please explain: _____
Stitches in the head or neck area? _____Yes _____No
If yes, please explain: _____
Tonsils and/or adenoids removed? _____Yes _____No
If yes, please explain: _____
Wisdom teeth/tooth removed? _____Yes _____No
If yes, please explain: _____
Other surgery(s) with a general anesthetic or a breathing tube? _____Yes _____No
If yes, please explain: _____
Play contact sports now? _____Yes _____No
If yes, please explain:_____
Play contact sports in the past- high school or college? _____Yes _____No
If yes, please explain: _____
Fall(s) on your face before you were 10 years old? _____Yes ___No
If yes, please explain:_____
Other facial trauma? _____Yes _____No
If yes, please explain: _____

23. Are you aware of your jaw making sounds? _____ Yes _____ No
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 CLOSED or partially closed? (can not open mouth) _____ Yes _____ No
If Yes, which side: _____ Right; _____ Left; _____ Both sides
Date of first occurrence ____/____/_____
Does it happen first thing in the morning? _____ Yes _____ No
If Yes, can you replace the jaw to normal position yourself? _____ Yes _____ No
If Yes, how many times has your jaw locked open during the past year? _____
If Yes, is there pain when your jaw locks open? _____ Yes _____ No

25. Has your jaw ever locked OPEN? (can't put teeth together) _____ Yes _____ No
If Yes, which side: _____ Right side; _____ Left side; _____ Both sides
Date of first occurrence _____
If Yes, how many times has your jaw locked closed or partially closed during the past year? _____
If Yes, is there pain when your jaw locks closed? _____ Yes _____ No

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

27. Do you need to move your jaw from side to side or forward to enable you to open or close your mouth?
_____ Yes _____ No
If yes, which side? _____ Right; _____ Left; _____ Both sides

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

29. Which side of your mouth do you prefer to chew on? ____ Right side ____ Left side ____ Don't know

30. Do you have pain when you chew? _____ Yes _____ No
Which side? _____ Right _____ Left _____ Both sides
What is the severity of the pain you are experiencing? Circle the appropriate number:
no pain 0 1 2 3 4 5 6 7 8 9 10 extreme pain

31. Have you ever had braces on your teeth? _____ Yes _____No
If yes, when and by whom? _____

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

33. Do you chew gum? _____ Yes _____ No
If yes, how much? _____ All Day
_____ All of School or Work
_____ Every day but not a lot. How many hours per day?_____
_____ A few times per week. How many hours each time?_____
_____ Rarely or Never

34. Do you clench your teeth? _____ Yes _____ No
When: Tense? _____ While sleeping?____ Other: _____

35. Do you grind your teeth? _____ Yes _____ No
When: Tense? _____ While sleeping? _____ Other: _____

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

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

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

39. Do you sleep well? _____ Yes _____ No _____ The pain problem is affecting my sleep.
How many hours of sleep do you get a night? _____ Is that enough sleep for you? _____ Yes _____ No

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

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

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

43. How many pillows do you sleep on? _____ What type? _____

44. Do you snore? _____Yes _____No
If Yes, Do you choke when you snore? _____Yes _____No

45. Have you been diagnosed with sleep apnea? _____Yes _____No

46. Do you feel you may have sleep apnea? _____ Yes _____ No

47. Are you stiff or sore when you wake up in the morning? _____ Yes _____ No

48. 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
Carbonated soft drinks _____ cans or bottles/day Tea _____ cups/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 (Check all 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. List ALL medications, drugs, or pills of any kind:
Medication_____ Reason:_____
Medication_____ Reason:_____
Medication_____ Reason:_____
Medication_____ Reason:_____
Medication_____ Reason:_____
Medication_____ Reason:_____

67. What types of health care provider(s) have you seen for your problem? (Check all that apply.)

___None	___General dentist	___Rheumatologist
___Rehabilitation medicine	___Physical Medicine	___Oral surgeon
___Pain clinic	___Anesthesiologist	___Orthodontist
___TMJ Specialist	___Family Physician	___Ophthalmologist
___Internist	___Osteopathic Physician	___Chiropractor
___Ear, Nose, Throat Physician	___Neurologist	___Neurosurgeon
___Orthopedic Surgeon	___Physical Therapist	___Other (See Below)

Please list the names of the above health care providers you have used:

_____

If other, please describe_____

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

___Traction	___Hypnosis	___Drug Rehab
___Botox or other injections	___Splint/bite plate	___Alcohol Rehab
___Acupuncture	___Counseling	___Chiropractic care
___Massage	___Medication	___Electrical Stimulation
___Nerve blocks	___Heat/Cold applications	___Ultrasound
___Biofeedback	___Acupressure	___Root canal/dental treatment
___Pain program	___Stress management	___Exercise
___TMJ Surgery	___Orthodontics/Braces	___Occlusal/bite adjustment

___Other (See below)

Who performed these treatments and when? _____

If other, please describe, when and who performed the treatment:_____

_____

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

69. Which tests have you had for the problem?

___CT Scan	___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/flow studies	___Nerve block
___EMG	___Don't know the name of the Xrays	___Other (See Below)

Who performed these tests and when? _____

If other, please describe_____