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)

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

_____

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

_____

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

_____

?How would you describe your overall physical health .4

Poor Average Excellent

10 9 8 7 6 5 4 3 2 1 0

?How would you describe your overall dental health

Poor Average Excellent

10 9 8 7 6 5 4 3 2 1 0

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

_____ ?If yes: by whom & when

Do you have pain in your face or jaw? _____ Yes _____ No .6

:What is the severity of the pain you are experiencing? Circle the appropriate number

no pain0 1 2 3 4 5 6 7 8 9 10 extreme pain

:Describe the pain .7

Dull _____ Aching _____ Burning_____ Throbbing _____

Pressure _____ Pulsating_____ Stabbing _____ Tiring/Exhausting _____

_____Sharp _____ Punishing/Cruel_____ Sickening_____Other _____

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

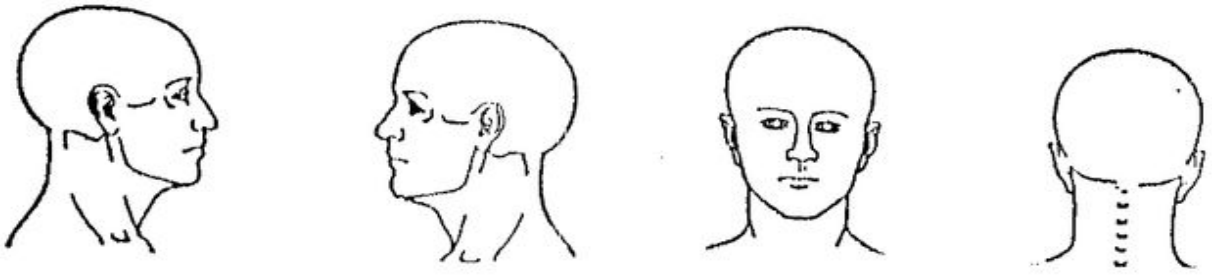
Yes _____ No _____

Pain moves up the side of the head _____

Pain moves around to the back of the head _____

Pain moves down the neck _____

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



How long have you had this pain? _____ years; _____ months; _____ weeks .10

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

?When do you have pain .11

Constantly_____ Frequently and predictably _____ Frequently, but not predictable _____

Occasionally_____ No real pattern _____

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

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

Work &/or School Days_____Mostly Day/Mostly Evening _____Hormonally related_____

_____ Other

?How long does the pain last .13

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

minutes _____ 1-5 hours_____ 13-24 hours _____ Constant 1-15 _____

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

_____If yes, please explain

?Do any of the following cause or aggravate the pain .15

Chewing _____ Yawning _____Lack of sleep _____

Opening mouth wide _____ Laughing _____ Exercise _____

Talking _____ Singing _____ Eating certain foods _____

Playing a musical instrument _____ Stress/emotional upset____ Nothing _____

_____ Sitting for a long periods of time _____Other _____

?What relieves the pain .16

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 _____ _____ Nothing _____

.Check any of the following that you experience .17

Numbness in the face or jaw ___Weakness in jaw muscles _____
_____:Other

Earache or stuffiness ___Ringing or buzzing in the ears___

Numbness/tingling in hands or fingers ___Dizziness ___ None of these___

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___

Do you have pain in the cheek/jaw? _____Yes _____No .18

If yes, which side? _____ Right_____ Left _____ Both sides

What is the severity of the pain you are experiencing? Circle the appropriate number:

no pain0 1 2 3 4 5 6 7 8 9 10 extreme pain

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

If yes, which side? _____ Right_____ Left _____ Both sides

What is the severity of the pain you are experiencing? Circle the appropriate number:

no pain0 1 2 3 4 5 6 7 8 9 10 extreme pain

Do you have pain in your neck? _____ Yes _____ No .20

What is the severity of the pain you are experiencing? Circle the appropriate number:

no pain0 1 2 3 4 5 6 7 8 9 10 extreme pain

Do you have pain in your back? _____ Yes _____ No .21

Which side? _____ Right; _____ Left; _____ Both; _____ Middle

What is the severity of the pain you are experiencing? Circle the appropriate number:

no pain0 1 2 3 4 5 6 7 8 9 10 extreme pain

Have you experienced: (Read ALL parts of this question.) .22

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: _____

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

If YES:Which side: _____Right _____ Left _____ Both sides

Describe nature of the sound:_____ Clicking _____ Popping_____ Grating_____ Cracking

_____ Other _____

When do you notice the sound?_____ Early opening _____ Moving jaw to the side

Middle opening _____ Chewing _____

Wide opening _____ While closing _____

Is the sound always present? _____ Yes _____ No

Is there pain associated with the sounds? _____ Yes _____ No _____ Sometimes

Has your jaw ever locked CLOSED or partially closed? (can not open mouth) _____ Yes _____ No .24

If YES:Which side: _____ Right; _____ Left; _____ Both sides

_____/____/____ Date of first occurrence

Does it happen first thing in the morning? _____ Yes _____ No

Can you replace the jaw to normal position yourself? _____ Yes _____ No

How many times has your jaw locked closed or partially during the past year? _____

Your Whole Life:_____

Is there pain when your jaw locks closed? _____ Yes _____ No

Has your jaw ever locked OPEN? (can't put teeth together) _____ Yes _____ No .25

If YES:Which side: _____ Right side; _____ Left side; _____ Both sides

Date of first occurrence ____/_____/_____

How many times has your jaw locked open during the past year? _____

Your Whole Life:_____

Is there pain when your jaw locks open? _____ Yes _____ No

When you open your mouth, does something in your jaw joint feel like it's in the way? ____ Yes ____ No .26

Which side? _____ Right; _____ Left; _____ Both sides

?Do you need to move your jaw from side to side or forward to enable you to open or close your mouth .27

Yes _____ No _____

If yes, which side? _____ Right; _____ Left; _____ Both sides

?What foods do you avoid eating because of this problem .28

_____ Hard foods _____ Chewy foods _____ None Other _____

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

Do you have pain when you chew? _____ Yes _____ No .30

Which side? _____ Right _____ Left _____ Both sides

What is the severity of the pain you are experiencing? Circle the appropriate number:

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31. Have you ever had braces on your teeth?_____ Yes _____No

If YES:When and by whom? _____

Do you wear your retainers nightly? _____ Yes _____No Other:_____

If Yes, Are they the original (first set) retainers? _____ Yes _____No _____ Don't Know

32. Do you have any other oral habits or practices that may aggravate or cause pain?

_____ Yes _____ No If yes, what? _____

33. List any activity, which holds the head or jaw in an imbalanced position. (Phone, swimming, instrument…)

Describe: _____

34. Do you play video/ phone/ tablet games? _____Yes _____No

If yes, how many hours a week?_____

35. For each of the beverages listed below, write in the average number you drink each day:

Caffeinated coffee _____ cups/dayDecaffeinated coffee _____ cups/day

Carbonated soft drinks _____ cans or bottles/dayTea _____ cups/day

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

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

38. 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

Do you clench your teeth? _____ Yes _____ No .39

_____ :When: Tense? _____ While sleeping?____ Other

Do you grind your teeth? _____ Yes _____ No .40

_____ :When: Tense? _____ While sleeping? _____ Other

?Do you feel that clenching or grinding your teeth causes or contributes to your pain .41

Yes _____ No _____ Sometimes _____

.Do you sleep well? _____ Yes _____ No _____ The pain problem is affecting my sleep .42

How many hours of sleep do you get a night? _____Is that enough sleep for you? _____ Yes _____ No

Do you awaken frequently during the night? _____ Yes _____ No .43

Do you go to bed more tired than your daily activities justify? _____ Yes _____ No .44

Do you feel rested when you get up in the morning? _____ Yes _____ No .45

_____ ?How many pillows do you sleep on? _____ What type .46

Do you snore? _____Yes _____No .47

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

Have you been diagnosed with sleep apnea? _____Yes _____No .48

Do you feel you may have sleep apnea? _____ Yes _____ No .49

Are you stiff or sore when you wake up in the morning? _____ Yes _____ No .50

Do you sleep on your stomach? _____Yes _____ No .51

52. Do you have headaches as often as once per week? _____ Yes _____ No

IF YES:How many per week? _____

Wake up with a headache? _____ Yes _____ No

Headaches later in the day? _____ Yes _____ No

Is there any nausea or vomiting associated with your headaches? _____ Yes _____ No

_____ ?If yes, how many per week

Are there vision changes associated with your headaches? _____ Yes _____ No

_____ ?If yes, what kind

Do you have more than one type of headache? _____ Yes _____ No

If yes, please list them: _____

What relieves the headache? _____ Rest _____ Sleep _____ Exercise

_____ ?Pain medication- If yes, what _____

_____ :Other _____

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

54. Do you feel that you are under stress much of the time?

_____ Yes _____ No _____ Occasionally

55. Does increased stress seem to make the pain problem and/or headaches worse?

_____ Yes _____ No _____ Occasionally

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

Stress Factors (Check all that applies to you.) .57

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 ___ None___

_____ Marital separation ___Other___

Are you presently, or have you ever been under the care of psychiatrist or a psychologist? _____ Yes _____ .58 No

:List ALL medications, drugs, or pills of any kind .59

_____:Medication_____ Reason

_____:Medication_____ Reason

_____:Medication_____ Reason

_____:Medication_____ Reason

_____:Medication_____ Reason

_____:Medication_____ Reason

What types of health care provider(s) have you seen for your problem? (Check all that apply.) .60

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

:Which of the following treatment(s) have you received for your pain .61

None ___Hypnosis ___Drug Rehab___

Medication ___Splint/bite plate ___Alcohol Rehab___

Acupuncture ___Counseling ___Chiropractic care___

Massage ___ Botox or other injections ___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___

Traction___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
_____

?Which tests have you had for the problem .62

None ___Myelogram ___Tooth pulp test___

___CT Scan ___Venogram ___Urine studies

TMJ MRI/X-ray ___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_____