



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?

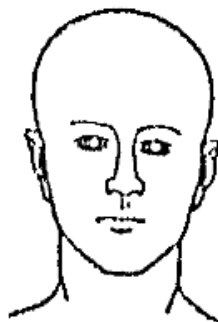
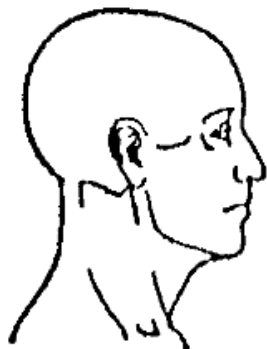
_____ Yes _____ No

_____ 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

_____ Nothing

_____ 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 _____

_____ Nothing

17. Check any of the following that you experience.

☐ 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	

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
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

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
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

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 ____/____/____
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

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? _____
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/day Decaffeinated coffee ____ cups/day
Carbonated soft drinks ____ cans or bottles/day Tea ____ 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
39. Do you clench your teeth? ____ Yes ____ No
When: Tense? ____ While sleeping? ____ Other: _____
40. Do you grind your teeth? ____ Yes ____ No
When: Tense? ____ While sleeping? ____ Other: _____
41. Do you feel that clenching or grinding your teeth causes or contributes to your pain?
____ Yes ____ No ____ Sometimes
42. 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
43. Do you awaken frequently during the night? ____ Yes ____ No
44. Do you go to bed more tired than your daily activities justify? ____ Yes ____ No
45. Do you feel rested when you get up in the morning? ____ Yes ____ No
46. How many pillows do you sleep on? ____ What type? _____

47. Do you snore? _____ Yes _____ No

If Yes, Do you choke when you snore? _____ Yes _____ No

48. Have you been diagnosed with sleep apnea? _____ Yes _____ No

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

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

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

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

57. 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

____ None

____ Marital separation

____ Other _____

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

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

Medication _____	Reason: _____
Medication _____	Reason: _____
Medication _____	Reason: _____
Medication _____	Reason: _____
Medication _____	Reason: _____
Medication _____	Reason: _____

60. 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 _____

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

☐ 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? _____

62. Which tests have you had for the problem?

☐ 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 _____