HEADACHE AND TEMPEROMANDIBULAR JOINT (TMJ) HISTORY QUESTIONAIRE

Patient Name_____ Age____ Date_____
Referred by_____Dentist_____

1.Which do you suffer from most? Headaches____, Neckaches____, Jaw pain_____ Facial pain____, Other_____
2. Where do you get them? Right side____, Left side____, Both sides____,
3. How long have you had this pain? _____
4. How frequently? Daily____, Weekly____, Monthly____, Occasionally____
5. Do you wake up with them? _____.
6. Do they develop during the day? _____.
7. Are they worse in the morning? ____, Afternoon____, Evening____.
8. On a scale of 1-10, with 10 being the worst pain imaginable, above the shoulders, how many mornings per week do you wake up with a "0"(zero)? _____.
9. On a scale of 1-10, what is the average "number" you usually wake up with? _____
10. What % of your *waking* time do you have some degree of headache?____
11. What % of your *waking* time do you have a "0"(zero) without taking medications? ____.
12. What is your average headache pain level (1-10 scale) throughout the day? _____.
13. On a scale of 1-10, what is the worst pain level you experience? _____.
14. What time of day do you usually experience you worst headaches? _____.
15. How many times per week(or month) might you experience your worst pain? ____.
16. Where does your pain seem to originate? _____.
17. How would you describe your pain? (examples: throbbing, squeezing, pressure, dull, stabbing, shooting, and so on)_____ _____
18. Please circle the types of health care providers you've seen for your headaches. MD, Neurologist, ENT, Internist, Physical Therapist, Chiropractor, Dentist, others:_____ _____
19. What medical tests have been performed regarding your headaches? CT Scan, MRI, X-rays, blood analysis, others: _____
20. What types of procedures or treatment (including dental) have you had regarding your headaches? _____

21.What medication(s) do you now take to prevent your headaches? _____
_____

22. What medication(s) have you tried to prevent your headaches? _____
_____

23. What prescriptions or over-the-counter medications do you take to relieve your headaches? (and how much)_____

24. Do you clench or grind your teeth? ____Day?_____, Night?_____Both?_____

25. Does it hurt to chew hard foods? ____Yawn? ____Talk? ____Open wide? _____, Swallow? _____

26. Do you have problems with your ears? _____Ringing? _____ Hearing loss? ____ Rushing sounds? _____, Dizziness? _____, Other? _____

27. Do your jaws "click"? _____, "pop"? _____, or make a grating sound? _____

28. How long have you noticed this? _____ Right side? ____ Left side? _____

29. Has your jaw ever locked closed or become stuck momentarily, or longer? _____ When did this first happen? _____ How many times has this occurred? _____ Could you unlock it? _____ How did you unlock it?
_____

30. Do you sleep on your back? ____, your right side? _____, your left side? ____ Or your stomach? ____Most of the time?

31. Is there any stress in your life (job, home, marital, children, and so on)? Please explain_____

32. Any information that you would like to add?
_____

_____

Shade in the areas below where you experience you discomfort