Houston TMJ
Facial Pain & Sleep

HEAD AND NECK PAIN EVALUATION QUESTIONNAIRE

Date: __ /__ /____
Patient Name: _____ D.O.B: __ / __ / ____

I) Referring Doctor and other doctors you would like to have reports sent to

Name of Doctor	Specialty	Phone Number	Fax Number

II) Understanding your pain

A. Describe in your own words the problem(s) you would like help with:
_____
_____
_____
_____

B. When did your problem begin? _____

C. How did your problem begin?

[ ] Surgery (Oral, Jaw, Neck, Head)
[ ] Motor vehicle accident
[ ] Chewing
[ ] Orthodontics (braces)
[ ] Infection (Ear, nose, throat, other)
[ ] Drug use (antibiotics, pain meds, other)
[ ] Nothing; pain just came on
[ ] Other_____

[ ] Blow to jaw / head / neck
[ ] Dental work
[ ] Tooth extraction
[ ] Stressful Situation

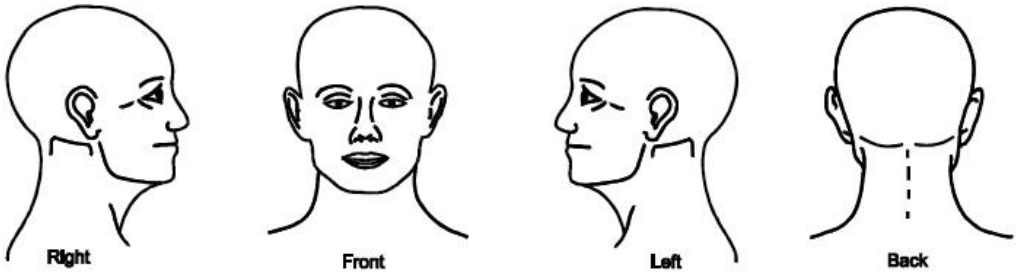
D. What is the usual severity of your pain? (Circle the appropriate number)

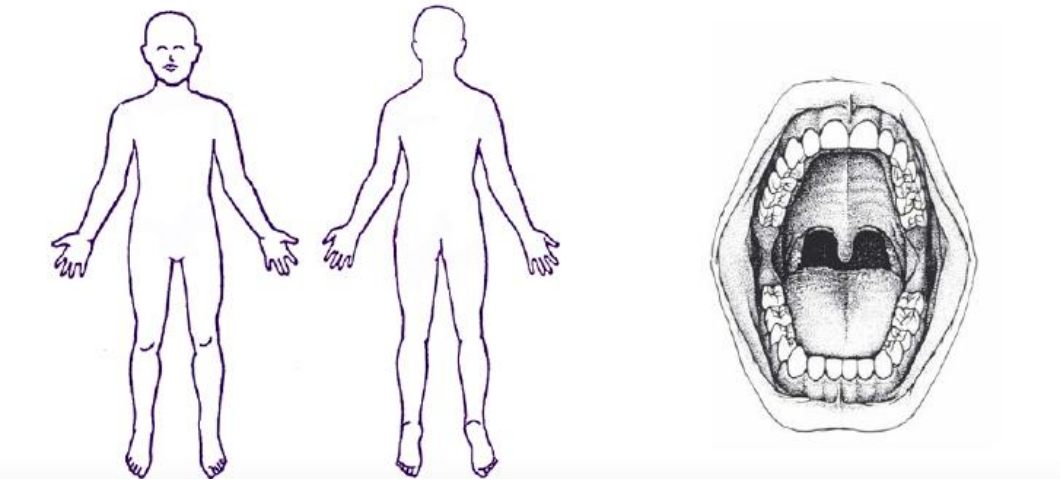
|_____|
0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

E. Describe the way your pain typically feels:

[ ] Throbbing	[ ] Gnawing	[ ] Splitting
[ ] Shooting	[ ] Hot / Burning	[ ] Tiring-exhausting
[ ] Stabbing	[ ] Aching	[ ] Sickening
[ ] Sharp	[ ] Heavy	[ ] Fearful
[ ] Cramping	[ ] Tender	[ ] Punishing – Cruel
[ ] Pressure	[ ] Electric shock-like	

F. On the diagrams below please mark the areas where you feel pain:





G. Describe the frequency of your pain: [ ] Intermittent [ ] Continuous

H. If your pain is intermittent, how often does it occur?

[ ] Several times a day	[ ] Once per week
[ ] Once per day	[ ] Less than once per week
[ ] Several times per week	[ ] Never

I. How long does your pain last?

[ ] Less than 1 minute	[ ] 6-12 hours
[ ] 1-10 minutes	[ ] 13-24 hours
[ ] Less than 1 hour	[ ] Several days
[ ] 1-5 hours	[ ] Constant

J. How many days during the past 30 days did you have the pain? _____ days

K. Which of the following causes or aggravates the pain?

[ ] Chewing	[ ] Opening mouth wide	[ ] Hot or cold foods/drinks
[ ] Talking	[ ] Lack of sleep	[ ] Damp or cold weather
[ ] Yawning	[ ] Playing musical instrument	[ ] Stress/emotional upset
[ ] Laughing	[ ] Riding in car for long period	[ ] Sitting for long period
[ ] Singing	[ ] Eating certain foods	[ ] Exercise

[ ] Other_____

L. Which of the following relieves the pain?

[ ] Exercise	[ ] Massage of the area	[ ] Warm soak/compresses
[ ] Heat	[ ] Holding jaw in certain position	[ ] Ice/cold compresses
[ ] Sleep	[ ] Moving/manipulating jaw	[ ] Drinking certain fluids
[ ] Time	[ ] Relaxation	[ ] Pain medication

[ ] Nothing helps

[ ] Other_____

M. Are you aware of your jaw making sounds?

[ ] Yes [ ] No

If yes, please answer the following questions **If no, go to question N.**

Which side? [ ] Right [ ] Left [ ] Both sides

Describe the nature of the sound:

[ ] Clicking [ ] Grating [ ] Popping [ ] Cracking

[ ] Other_____

Is the sound always present?

[ ] Yes [ ] No

Do you feel that the sounds are related to your pain?

[ ] Yes [ ] No

N. Has your jaw ever locked open?

[ ] Yes	[ ] Right side	[ ] Both sides
[ ] No	[ ] Left side	

Date of first occurrence_____

If Yes, can you replace the jaw to normal position yourself?

[ ] Yes [ ] No

O. Has your jaw ever locked closed or partially closed?

[ ] Yes [ ] No [ ] Right side [ ] Left side [ ] Both sides

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

[ ] none # of times_____

Do you have pain when your jaw locks open or closed?

[ ] Yes [ ] No

P. Have you noticed any other oral habits or practices that aggravate or cause pain?

[ ] Clenching the teeth
[ ] Grinding the teeth
[ ] Chewing ice
[ ] Chewing finger nails
[ ] Chewing pencil/paper clips
[ ] Chewing cheek/lips
[ ] Holding phone between ear and shoulders
[ ] Playing wind instruments/violin
[ ] Other_____

A. Do you chew gum? [ ] Yes [ ] No
If yes, how often? [ ] Daily [ ] Weekly [ ] Rarely

Q. 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
[ ] Neck pain
[ ] Pain in back of head
[ ] Back pain
[ ] Morning stiffness
[ ] Easily fatigued
[ ] Jaw catching
[ ] Aches and pains all over body
[ ] Change in ability to taste
[ ] Unusual tastes
[ ] Decreased ability to open your mouth
[ ] Numbness/tingling in hands or fingers

III) Headaches

A) Are you bothered by headaches?
[ ] Yes [ ] No
If yes, please answer the following questions.
If no, go to section IV.

B) a) On average, how painful are your headaches?

|_____|
0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

C) Do you have headaches as often as once per week? [ ] Yes [ ] No

D) Do you have more than one type of headache? [ ] Yes [ ] No

E) Do you wake up in the morning with a headache? [ ] Yes [ ] No

F) Do you have headaches later in the day? [ ] Yes [ ] No

G) Do headaches wake you up from sleep? [ ] Yes [ ] No

H) Is there any nausea or vomiting associated with your headaches?
[ ] Yes [ ] No

I) Do you have sensitivity to light associated with your headaches?
[ ] Yes [ ] No

J) Do you have sensitivity to sounds associated with your headaches?
[ ] Yes [ ] No

K) What relieves the headache?
[ ] Rest [ ] Nothing [ ] Sleep [ ] Exercise
[ ] Pain Medications; which ones_____

L) Does physical activity make your pain: [ ] Better [ ] Worse

M) Do any of these symptoms occur with your headache?
[ ] Eyelid drooping [ ] Redness of the eye(s) [ ] Tearing of the eye(s)
[ ] Nasal stuffiness [ ] Nasal stuffiness [ ] Face sweating

N) Has a headache limited your activities for a day or more in the last 3 months? [ ] Yes [ ] No

IV) Sleep

A) How would you rate your sleep quality?

|_____|
0 1 2 3 4 5 6 7 8 9 10
Worst sleep quality Best sleep quality

B) How would you rate your sleep quantity?

|_____|
0 1 2 3 4 5 6 7 8 9 10
Low sleep quantity High sleep quantity

V) Effects of pain

A) Circle the number of how much your pain has interfered with your activities this **past week.**

|_____|
0 1 2 3 4 5 6 7 8 9 10

B) Circle the number of how bothered or upset you have been about the pain in the **past week.**

|_____|
0 1 2 3 4 5 6 7 8 9 10

C) Circle the number to indicate how much your pain has interfered with your sleep this **past week.**

|_____|
0 1 2 3 4 5 6 7 8 9 10

VI) Previous doctors and treatments

A) List ALL doctors you have seen for your pain problem

Date	Name	Specialty	Address/Phone/Fax (if available)

B) Diagnostic Tests (MRI, CT SCANS, PANORAMIC AND DENTAL X-RAYS, BLOOD TESTS, ETC.):

Please list, in chronological order, all tests and x-rays preformed to evaluate your pain:

Date	Test	Results

A) Previous treatments:

Indicate which of the following treatments you have tried for your problem:

[ ] Acupuncture
[ ] Biofeedback
[ ] Hypnosis
[ ] Pain program
[ ] Physical therapy
[ ] Chiropractor
[ ] Massage therapy
[ ] Bite guards/splints
[ ] Orthodontics/braces
[ ] Homeopathy
[ ] Counseling
[ ] Injections
[ ] Botox
[ ] Nerve blocks
[ ] Heat/cold applications
[ ] Occlusal/bite adjustments
[ ] Root canal/dental treatment
[ ] TMJ surgery
[ ] Other: _____
[ ] Medications (please list them):

_____
_____
_____
_____
_____

VII) Psychosocial history

A) Do you have problems with any of the following:

[ ] Depression	[ ] Concentration	[ ] Mood disorders
[ ] Anxiety	[ ] Motivation	[ ] Suicidal thoughts
[ ] Sleep	[ ] Self-esteem	[ ] Homicidal thoughts

[ ] Post-traumatic stress disorder (PTSD)
[ ] History of physical/psychological abuse

B) Do you currently go to therapy/counseling? [ ] Yes [ ] No
If yes, which type of provider do you see?

[ ] Therapist	[ ] Counselor
[ ] Psychologist	[ ] Psychiatrist

VIII) Other

A) Have you or will you consult a lawyer regarding your pain problem?
Yes___ No___

B) Are you receiving or applying for disability?
[ ] Yes [ ] No

Please list any additional information or comments about your pain problem: