

Version: TMDQUES1

Head, Neck and Facial Pain Questionnaire

OFFICE USE
Patient ID: _____

NAME: _____

CURRENT DATE: ____/____/____

DATE OF BIRTH: ____/____/____

MALE

FEMALE

Referring Physician: _____

Contact ID: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe, #2 the next most severe, etc.

2. Then rate your complaints for frequency and intensity:

Frequency

1-SELDOM 2-OCCASIONAL 3-FREQUENT
4-EVERYDAY

Intensity

0=NO PAIN and 10 is MOST SEVERE PAIN

Number #1 = the most severe symptom		Frequency 1-4	Intensity 1-10
<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Jaw clicking	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Jaw locking	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Limited mouth opening	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Facial pain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>

Number #1 = the most severe symptom		Frequency 1-4	Intensity 1-10
<input type="checkbox"/>	Morning head pain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Nocturnal teeth grinding	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Frequent Heavy Snoring	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Pain when chewing	<input type="checkbox"/>	<input type="checkbox"/>

Other: Write In

Symptoms

HEAD PAIN

Unsupported Control
Unsupported Control
Unsupported Control
Unsupported Control
Unsupported Control

JAW PAIN

Jaw pain - on opening
 Jaw pain - while chewing
 Jaw pain - at rest

JAW SYMPTOMS

Jaw popping
 Jaw clicking
 Jaw locks closed
 Jaw locks open
 Teeth grinding

MOUTH AND NOSE RELATED CONDITION

Burning tongue
 Frequent biting of cheek

Patient Signature: _____

Date: _____

Symptoms

MOUTH AND NOSE RELATED CONDITION

- Frequent snoring
- Broken teeth
- Teeth clenching
- Dry mouth

EAR RELATED CONDITIONS

- Buzzing in the ears
- Tinnitus (ringing in the ears)
- Ear pain
- Pain in front of the ear
- Pain behind the ear

EYE RELATED CONDITIONS

- Blurred vision
- Eye pain
- Tightness in throat

Other

- Pain or pressure behind the eyes

THROAT, NECK & BACK RELATED CONDITIONS CONTINUED

- Back pain - lower
- Back pain - middle
- Back pain - upper
- Limited movement of neck
- Neck pain
- Numbness in the hands or fingers
- Shoulder pain
- Tingling in the hands or fingers
- Ear congestion
- Difficulty in swallowing
- Sciatica
- Shoulder stiffness

History Of Symptoms

Is there anything that makes your pain or discomfort worse?

What other information is important regarding the pain or condition?

Is there anything that makes your pain or discomfort better?

Other

History Of Accident

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THE CURRENT VISIT:

DATE OF ACCIDENT OR INCIDENT:

Enter date (month/day/year)

THE PATIENT BELIEVES THE CAUSE OF THE PAIN OR CONDITION TO BE:

Select one:

- A motor vehicle accident

Patient Signature:

Date:

History Of Accident

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THE CURRENT VISIT:

THE PATIENT BELIEVES THE CAUSE OF THE PAIN OR CONDITION TO BE:

Select one:

- A motorcycle accident
- A work related incident
- A playground incident
- An athletic endeavor
- A fight
- A fall
- An accident
- Hit by an object
- Hit an object
- An illness
- An injury
- Orthodontics
- Dental procedures
- Whiplash
- Other:

HISTORY OF ACCIDENT

WERE YOU:

Select one:

- A passenger in a motor vehicle
- The driver of a vehicle
- A pedestrian
- At work
- Did you fall?
- Were you hit by an object?
- Did you hit an object?
- Other:

Patient Signature:

Date:

History Of Accident

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THE CURRENT VISIT:

IF IN A VEHICLE, WHERE WAS THE VEHICLE HIT?

- | | |
|--|--|
| <input type="checkbox"/> At the front end | <input type="checkbox"/> Head on |
| <input type="checkbox"/> At the rear end | <input type="checkbox"/> On driver's side |
| <input type="checkbox"/> At the front right area | <input type="checkbox"/> On passenger's side |
| <input type="checkbox"/> At the front left area | Other area: <input style="width: 150px;" type="text"/> |
| <input type="checkbox"/> At the rear right area | |
| <input type="checkbox"/> At the rear left area | |

INDICATE IF THERE WAS ANY TRAUMA:

The patient's:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Forehead | <input type="checkbox"/> Top of head |
| <input type="checkbox"/> Face | <input type="checkbox"/> Teeth |
| <input type="checkbox"/> Chin | <input type="checkbox"/> Jaw |
| <input type="checkbox"/> Side of head | Other: <input style="width: 150px;" type="text"/> |
| <input type="checkbox"/> Back of head | |

Forcibly struck the:

- | | |
|--|---|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Headrest |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Seat |
| <input type="checkbox"/> Passenger's side window | <input type="checkbox"/> Roof |
| <input type="checkbox"/> Driver's side window | <input type="checkbox"/> Interior of the car |
| <input type="checkbox"/> Passenger's side door | Other: <input style="width: 150px;" type="text"/> |
| <input type="checkbox"/> Driver's side door | |

Head Pain History

Pain Qualities

--- LOCATION ---

Which side are the headaches worse?

- both sides
 the left side
 the right side

Headache spreads to

- the temple, the back of the head, and the forehead
 the temple, the back of the head, and the forehead
 the temple
 the back of the head
 the temple
 the back of the head
 the forehead

Patient Signature:

Date:

Head Pain History

Pain Qualities

--- LOCATION ---

--- DURATION ---

Seconds

--- SEVERITY ON A SCALE OF 0-10 ---

Minutes

--- 0=No Pain 10=Worst Pain Imaginable ---

Hours

Jaw Pain on a Numeric Pain Scale

Days

Headaches on a 0-10 Pain Scale

Weeks

Neck Pain on a Numeric Pain Scale

Facial Pain on a 0-10 Pain Scale

occasional (0-3/mo)

frequent (3-6/mo)

FREQUENCY

constant

several days/weeks

When having pain do you experience:

Dizziness

Sensitivity to noise

Double vision

Throbbing

Fatigue

Vomiting

Nausea




Burning

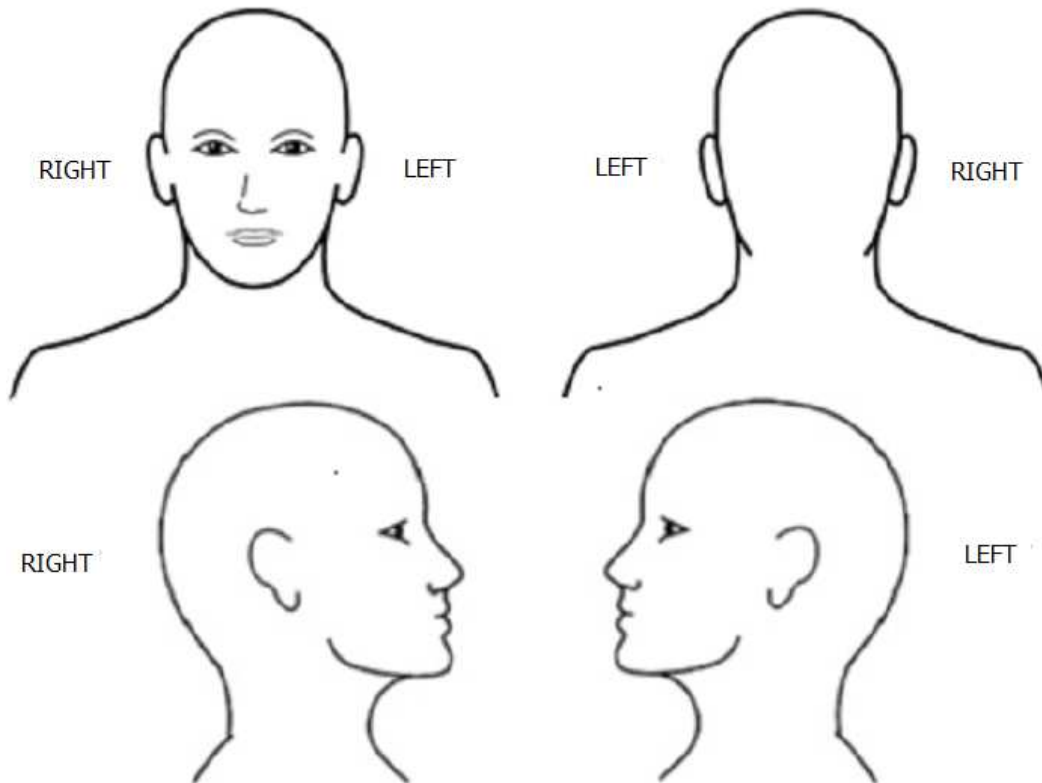
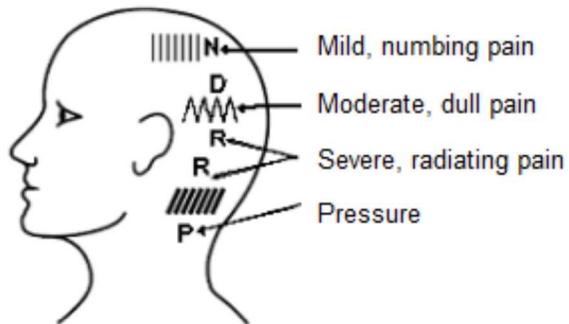
Sensitivity to light (photophobia)

Other

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

- | | | |
|---------------|---|--------------------|
| MILD PAIN |  | B Burning |
| | | D Dull |
| | | N Numbing |
| MODERATE PAIN |  | P Pressure |
| | | S Sharp |
| SEVERE PAIN |  | T Tingling |
| | | R Radiating |



Enter any text to appear below the image:

Patient Signature:

Date:

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature:

Date:

I certify that the medical history information is complete and accurate.

Patient Signature:

Date: