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	Number #1 = the most severe symptom		Frequency 1-4	Intensity 1-10
☐	Jaw pain	☐	☐	☐	Morning head pain	☐	☐
☐	Jaw clicking	☐	☐	☐	Ringing in the ears	☐	☐
☐	Jaw locking	☐	☐	☐	Dizziness	☐	☐
☐	Limited mouth opening	☐	☐	☐	Nocturnal teeth grinding	☐	☐
☐	Facial pain	☐	☐	☐	Frequent Heavy Snoring	☐	☐
☐	Neck pain	☐	☐	☐	Pain when chewing	☐	☐
☐	Headaches	☐	☐				
☐	Migraines	☐	☐				

Other: Write In

Symptoms

HEAD PAIN

Unsupported Control
Unsupported Control
Unsupported Control
Unsupported Control
Unsupported Control

JAW PAIN

L R B Jaw pain - on opening
L R B Jaw pain - while chewing
L R B Jaw pain - at rest

JAW SYMPTOMS

☐ Jaw popping
L R B 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
- ☐ 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

Other ______________ ______________

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?

- ☐ At the front end
- ☐ At the rear end
- ☐ At the front right area
- ☐ At the front leftt area
- ☐ At the rear right area
- ☐ At the rear left area
- ☐ Head on
- ☐ On driver's side
- ☐ On passenger's side
- Other area: ______

INDICATE IF THERE WAS ANY TRAUMA:

The patient's:

- ☐ Forehead
- ☐ Face
- ☐ Chin
- ☐ Side of head
- ☐ Back of head
- ☐ Top of head
- ☐ Teeth
- ☐ Jaw
- Other: ______

Forcibly struck the:

- ☐ Steering wheel
- ☐ Windshield
- ☐ Passenger's side window
- ☐ Driver's side window
- ☐ Passenger's side door
- ☐ Driver's side door
- ☐ Headreast
- ☐ Seat
- ☐ Roof
- ☐ Interior of the car
- Other: ______

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 forhead ☐ the temple, the bakcl of the head, and the forhead ☐ 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 ---

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

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

- [ ] Jaw Pain on a Numeric Pain Scale
- [ ] Headaches on a 0-10 Pain Scale
- [ ] Neck Pain on a Numeric Pain Scale
- [ ] Facial Pain on a 0-10 Pain Scale

FREQUENCY

- [ ] occasional (0-3/mo)
- [ ] frequent (3-6/mo)
- [ ] constant
- [ ] several days/weeks
- [ ] ____________

--- DURATION ---

- [ ] Seconds
- [ ] Minutes
- [ ] Hours
- [ ] Days
- [ ] Weeks

When having pain do you experience:

- [ ] Dizziness
- [ ] Double vision
- [ ] Fatigue
- [ ] Nausea
- [ ] Sensitivity to light (photophobia)
- [ ] Sensitivity to noise
- [ ] Throbbing
- [ ] Vomiting
- [ ] Burning

Other ____________ ____________

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN ||||||
MODERATE PAIN
SEVERE PAIN

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

Mild, numbing pain
Moderate, dull pain
Severe, radiating pain
Pressure

RIGHT LEFT LEFT RIGHT

RIGHT LEFT

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: