HEAD, NECK AND FACIAL PAIN QUESTIONNAIRE

Form 401A

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION

TODAY'S DATE _____

☐ MR. ☐ MS. ☐ MISS ☐ MRS. ☐ DR. NAME: _____
First Middle Initial Last

AGE: _____ BIRTH DATE: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

RESPONSIBLE PARTY: _____

FAMILY DENTIST: _____

ADDRESS: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

REFERRED BY: _____

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

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

2. Then rate your complaints for frequency and intensity:

Frequency:
(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

Intensity:
(0 is NO PAIN and 10 is MOST SEVERE PAIN)

Number		Frequency	Intensity
#1 = the most severe symptom		1-4	0-10
___	Back Pain	___	___
___	Dizziness	___	___
___	Ear Congestion	___	___
___	Ear Pain	___	___
___	Eye Pain	___	___
___	Facial Pain	___	___
___	Fatigue	___	___
___	Headaches	___	___
___	Inability to open mouth	___	___
___	Jaw Clicking	___	___
___	Jaw Joint Noises	___	___
___	Jaw Locking	___	___
___	Jaw Pain	___	___
___	Limited Mouth Opening	___	___
___	Migraine Headaches	___	___
___	Muscle Twitching	___	___
___	Neck Pain	___	___
___	Pain when Chewing	___	___
___	Ringing in the Ears	___	___
___	Shoulder Pain	___	___
___	Sinus Congestion	___	___
___	Throat Pain	___	___
___	Visual Disturbances	___	___
	Other - write in:		
___	_____	___	___
___	_____	___	___

Patient Signature _____

Date _____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Barbiturates
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Other _____ _____ _____ _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Y☐ N☐ Antibiotics
Y☐ N☐ Anticoagulants
Y☐ N☐ Barbiturates
Y☐ N☐ Blood thinners
Y☐ N☐ Codeine
Y☐ N☐ Cortisone
Y☐ N☐ Diet pills
Y☐ N☐ Heart medication
Y☐ N☐ Insulin
Y☐ N☐ Muscle relaxants
Y☐ N☐ Nerve pills
Y☐ N☐ Pain medication
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs
Y☐ N☐ Tranquilizers

Other _____ _____ _____ _____

PLEASE LIST ANY TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

	Practitioner	Specialty	Treatment & approximate date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

MEDICAL HISTORY (Please indicate dates on questions checked YES)

Y☐ N☐ Adenoids Removed
Y☐ N☐ Tonsils Removed
Y☐ N☐ Anemia
Y☐ N☐ Arteriosclerosis
Y☐ N☐ Asthma
Y☐ N☐ Autoimmune disorders
Y☐ N☐ Bleeding easily
Y☐ N☐ Blood pressure ☐High ☐Low
Y☐ N☐ Bruising easily
Y☐ N☐ Cancer
Y☐ N☐ Chemotherapy
Y☐ N☐ Chronic fatigue
Y☐ N☐ Cold hands & feet
Y☐ N☐ Current pregnancy
Y☐ N☐ Depression
Y☐ N☐ Diabetes
Y☐ N☐ Difficulty concentrating
Y☐ N☐ Dizziness
Y☐ N☐ Emphysema
Y☐ N☐ Epilepsy
Y☐ N☐ Excessive thirst
Y☐ N☐ Fibromyalgia
Y☐ N☐ Fluid retention
Y☐ N☐ Frequent cough
Y☐ N☐ Frequent illnesses
Y☐ N☐ Frequent stressful situations
Y☐ N☐ General anesthesia
Y☐ N☐ Glaucoma
Y☐ N☐ Gout
Y☐ N☐ Hay fever
Y☐ N☐ Hearing impairment
Y☐ N☐ Heart murmur
Y☐ N☐ Heart disorder
Y☐ N☐ Heart pacemaker
Y☐ N☐ Heart palpitations
Y☐ N☐ Heart valve replacement
Y☐ N☐ Hemophilia
Y☐ N☐ Hepatitis
Y☐ N☐ Hypoglycemia

Patient Signature _____ Date _____

MEDICAL HISTORY CONTINUED

Y☐ N☐ Immune system disorder
Y☐ N☐ Injury to
☐ Face ☐ Mouth
☐ Neck ☐ Teeth
Y☐ N☐ Insomnia
Y☐ N☐ Intestinal disorders
Y☐ N☐ Jaw joint surgery
Y☐ N☐ Kidney problems
Y☐ N☐ Liver disease
Y☐ N☐ Meniere's disease
Y☐ N☐ Menstrual cramps
Y☐ N☐ Multiple sclerosis
Y☐ N☐ Muscle aches
Y☐ N☐ Muscle shaking (tremors)
Y☐ N☐ Muscle spasms or cramps

Y☐ N☐ Muscular dystrophy
Y☐ N☐ Needing extra pillows to help breathing at night
Y☐ N☐ Nervous system irritability
Y☐ N☐ Nervousness
Y☐ N☐ Neuralgia
Y☐ N☐ Osteoarthritis
Y☐ N☐ Osteoporosis
Y☐ N☐ Ovarian cysts
Y☐ N☐ Parkinson's disease
Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Psychiatric care
Y☐ N☐ Radiation treatment
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Scarlet fever

Y☐ N☐ Shortness of breath
Y☐ N☐ Sinus problems
Y☐ N☐ Skin disorder
Y☐ N☐ Slow healing sores
Y☐ N☐ Speech difficulties
Y☐ N☐ Stroke
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Tendency for:
☐ Frequent Colds
☐ Ear Infections
☐ Sore Throats
Y☐ N☐ Tired muscles
Y☐ N☐ Tuberculosis
Y☐ N☐ Tumors
Y☐ N☐ Urinary disorders
Y☐ N☐ Wisdom teeth (Third Molar) extraction

Other _____

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN LOCATION	SEVERITY			FREQUENCY			DURATION				
	MILD	MODERATE	SEVERE	OCCASIONAL (MONTHLY OR LESS)	FREQUENT (WEEKLY)	CONSTANT (EVERY DAY)	SECONDS	MINUTES	HOURS	DAYS	WEEKS
L R B Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

Y☐ N☐ Jaw clicks
Y☐ N☐ Jaw locks closed
Y☐ N☐ Jaw locks open
Y☐ N☐ Jaw popping
Y☐ N☐ Teeth clenching
Y☐ N☐ Teeth grinding

EYE RELATED CONDITIONS

Y☐ N☐ Blurred vision
Y☐ N☐ Double vision
Y☐ N☐ Eye pain
Y☐ N☐ Pain or pressure behind the eyes
Y☐ N☐ Photophobia (extreme sensitivity to light)

EAR RELATED CONDITIONS

Y☐ N☐ Buzzing in the ears
Y☐ N☐ Ear congestion
Y☐ N☐ Ear pain
Y☐ N☐ Hearing loss
Y☐ N☐ Pain behind the ear
Y☐ N☐ Pain in front of the ear
Y☐ N☐ Recurrent ear infections
Y☐ N☐ Tinnitus (ringing in the ear)

THROAT NECK & BACK RELATED CONDITIONS

Y☐ N☐ Back pain - lower
Y☐ N☐ Back pain - middle
Y☐ N☐ Back pain - upper
Y☐ N☐ Chronic sore throat
Y☐ N☐ Constant feeling of a foreign object in throat
Y☐ N☐ Difficulty in swallowing
Y☐ N☐ Limited movement of neck
Y☐ N☐ Neck pain
Y☐ N☐ Numbness in the hands or fingers

Patient Signature _____ Date _____

THROAT NECK & BACK RELATED CONDITIONS (Continued)

Y☐ N☐ Sciatica
Y☐ N☐ Scoliosis
Y☐ N☐ Shoulder pain
Y☐ N☐ Shoulder stiffness
Y☐ N☐ Swelling in the neck
Y☐ N☐ Swollen glands
Y☐ N☐ Thyroid enlargement
Y☐ N☐ Tightness in throat
Y☐ N☐ Tingling in the hands or fingers
Y☐ N☐ Torticollis

MOUTH & NOSE RELATED CONDITIONS

Y☐ N☐ Broken teeth
Y☐ N☐ Burning tongue
Y☐ N☐ Chronic sinusitis
Y☐ N☐ Dry mouth
Y☐ N☐ Frequent biting of cheek
Y☐ N☐ Frequent snoring

Other _____

HISTORY OF SYMPTOMS

When did your condition first occur? _____

_____

What do you believe is the cause of your pain or condition?

Pick one:

☐ Motor vehicle accident ☐ Motorcycle accident ☐ Work related incident ☐ Playground incident
☐ Athletic endeavor ☐ Fight ☐ Fall ☐ Accident ☐ Illness ☐ Injury
☐ Unknown ☐ Other _____

If accident, date _____

Is there anything that makes your pain or discomfort worse? _____

Is there anything that makes your pain or discomfort better? _____

What other information is important to your pain or condition? _____

_____

FAMILY HISTORY

Have any members of your family (blood kin) had: Y☐ N☐ Headaches Y☐ N☐ High blood pressure
Y☐ N☐ Heart disease Y☐ N☐ Diabetes

SOCIAL HISTORY

Occupation _____

Do you have children? Y☐ N☐ If yes, how many children? _____ What are their ages? _____

Y☐ N☐ Are you currently under unusual stress?
Y☐ N☐ Recent change in lifestyle?
Y☐ N☐ Do you exercise regularly?

Y☐ N☐ Do you chew tobacco?
Number of caffeine drinks per day _____

Y☐ N☐ Do you smoke?

_____ *Number of* ☐ Packs ☐ Cigarettes *per* ☐ Day ☐ Week

Alcohol consumption

☐ None ☐ Social Drinker
☐ Occasional ☐ Daily

Patient Signature _____ Date _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

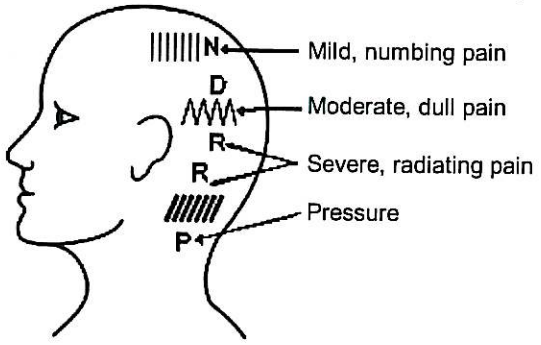
MILD PAIN

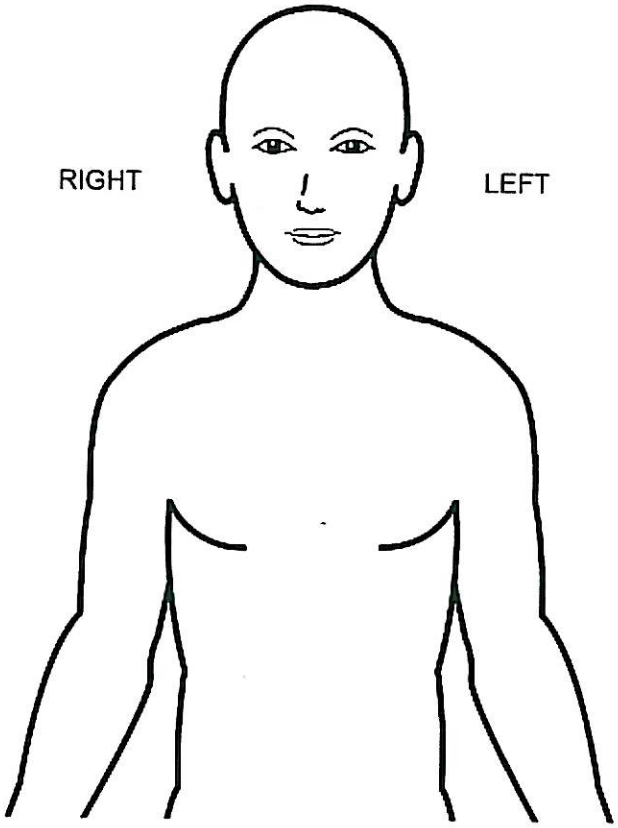
MODERATE PAIN

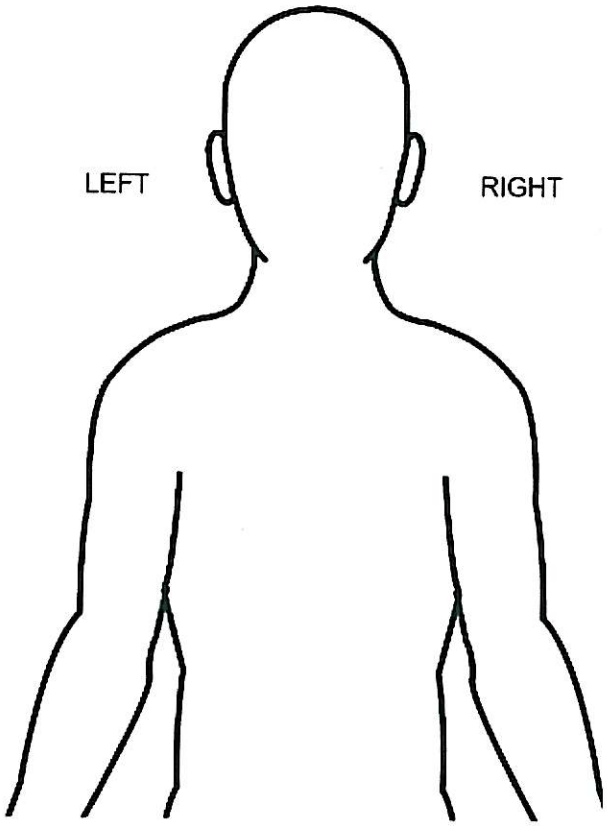
SEVERE PAIN

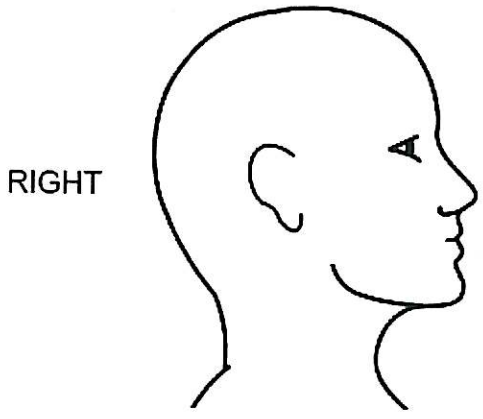
B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

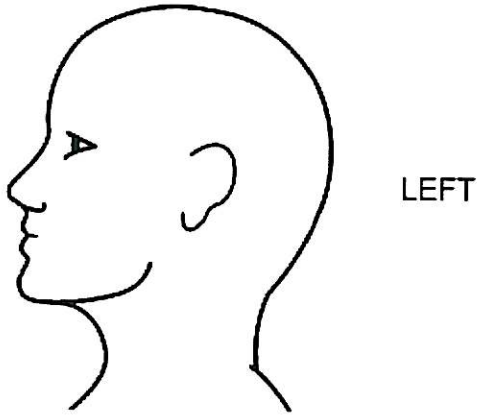
EXAMPLE











Patient Signature _____ Date _____

HISTORY OF ACCIDENT

IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT, COMPLETE THIS SECTION.

DATE OF ACCIDENT OR INCIDENT _____

WERE YOU ? (Choose one)

- ☐ A passenger in a vehicle
- ☐ The driver of a vehicle
- ☐ A pedestrian
- ☐ At work

AND... (Choose one)

- ☐ Did you fall?
- ☐ Were you hit by an object?
- ☐ Did you hit an object?
- ☐ Other _____

IF IN A VEHICLE WHERE WAS THE VEHICLE HIT?

- ☐ At front end
- ☐ At rear end
- ☐ At front right area
- ☐ At front left area
- ☐ At rear right area
- ☐ At rear left area
- ☐ Head on
- ☐ On driver's side
- ☐ On passenger's side
- ☐ Other _____

INDICATE IF THERE WAS ANY DIRECT TRAUMA.

DID YOUR

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

FORCIBLY STRIKE

- ☐ Steering wheel
- ☐ Windshield
- ☐ Passenger's side window
- ☐ Driver's side window
- ☐ Passenger's side door
- ☐ Driver's side door
- ☐ Headrest
- ☐ Seat
- ☐ Roof
- ☐ Interior of car
- ☐ Other _____

WERE ANY AREAS OF YOUR BODY PAINFUL SHORTLY AFTER THE ACCIDENT/INCIDENT?

- ☐ Head
- ☐ Neck
- ☐ Face
- ☐ Jaw
- ☐ Left shoulder
- ☐ Right shoulder
- ☐ Left arm
- ☐ Right arm
- ☐ Lower back
- ☐ Upper back
- ☐ Other: _____

BRIEFLY DESCRIBE THE HISTORY OF SYMPTOMS, ACCIDENT OR INCIDENT: _____

_____

_____

DID YOU GO TO THE HOSPITAL? ☐ Yes ☐ No ☐ By Car ☐ By Ambulance

☐ TAKEN TO THE HOSPITAL FOR X-RAYS & EVALUATION

WERE YOU ☐ SUBSEQUENTLY RELEASED ON (Date) _____

WHICH HOSPITAL? _____

HAS A DOCTOR OR DENTIST EVER DIAGNOSED A TMJ DISORDER PRIOR TO THE ACCIDENT?

☐ Yes ☐ No If yes, please explain _____

_____

Patient Signature _____ Date _____

TMJ PROBLEM QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS | DO NOT WRITE IN THIS SPACE

I. Name _____ Date _____

Age _____ Referred by _____

II. Which of the following do you have?

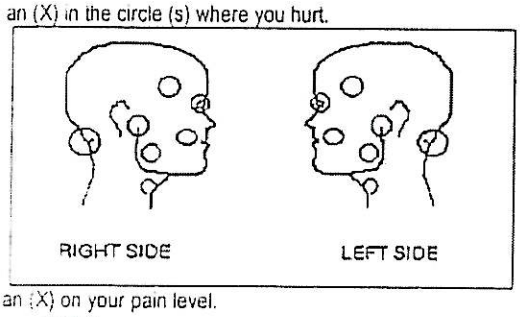
Headaches Neck pain Jaw pain Ear pain

Facial pain Other _____

Which side hurts (circle one) Right Left Both

Comments _____

III. Place an (X) in the circle (s) where you hurt.



Place an (X) on your pain level.

RIGHT		LEFT
0 1 2 3 4 5 6 7 8 9 10	BEST	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	AVG	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	WORST	0 1 2 3 4 5 6 7 8 9 10

IV. How long have you had this pain? _____

Is this pain constant? Y N

Is the pain (circle all that apply) Aching Burning Stabbing

Other _____

V. Is the pain worst in the (circle all that apply)

Morning Afternoon Evening Night

VI. Have you ever injured or sustained any form of trauma or whiplash to your (circle all that apply) Jaw Head Neck

(If so, please complete seperate Trauma Questionnaires for each trauma or whiplash)

VII. What makes the pain better? _____

What makes the pain worse? _____

What medication(s) do you take or have previously taken for your pain?

MEDICATION DOSE FREQUENCY

TMJ PROBLEM QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS	DO NOT WRITE IN THIS SPACE

Name: _____ Date _____

VIII. Does it hurt to chew? Y N
Does it hurt to open wide? Y N
Which side of your jaw makes a popping noise? L R
Which side of your jaw makes a clicking noise? L R
Which side of your jaw makes other noises? L R
What noises? _____
When did you first notice joint noises? _____

IX. Has your jaw ever locked? Y N
Did it lock open or closed? Open Closed
When did this first happen? _____
When did this last happen? _____
Has your jaw ever slipped out of place? Y N
Which side? L R

X. Have you noticed a change in your bite? Y N
Did you notice a change at your front teeth? Y N
Did you notice a change at your back teeth? Y N
Has your profile changed? Y N
Have you noticed any crookedness or asymmetry in your jaw? Y N
When did you notice the asymmetry? _____

XI. Are your teeth sore or sensitive? Y N
Do you clench your teeth? Y N
Do you grind your teeth? Y N
Do you do this during the day or night? Day Night
When did you start clenching or grinding? _____

XII. Do you have problems with your ears? Y N _____
Dizziness? Y N Ringing? Y N
Hearing? Y N Other? _____

XIII. Is it difficult to swallow? Y N
Is it painful to swallow? Y N
Have you noticed lumps in your face? Y N
Throat? Y N Neck? Y N
Other _____

XIV. Have you had any prior treatment for TMJ? Y N
Splint? Y N When? _____
Nightguard? Y N When? _____
Did it help? Y N
Bite Adjustment? Y N When? _____
Orthodontics? Y N When? _____
Did it help? Y N
Surgery? Y N When? _____
What type and which side? _____
_____
Did it help? Y N
Explain _____
_____
_____

TMJ PROBLEM QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS	DO NOT WRITE IN THIS SPACE

Name _____ Date _____

XV. Describe your problems as you understand them:

_____

_____

_____

_____

_____

XVI. Reports may be sent to my:

Medical Doctor _____

Dentist _____

Other _____

XVII. I have completed the above to the best of my knowledge and I consent to the use of my x-rays, records and photos for scientific publication or teaching providing my name remains anonymous.

_____

Signature

_____

Date

Dr. D Wilkerson
111 2nd Avenue NE, #1104
St. Petersburg, FL 33701

TMJ SCALE™

ADA ACCEPTED American Dental Association

Pain Resource Center

This questionnaire is designed to help your doctor evaluate your problem. Please answer all questions as honestly as possible. Use a **dark #2 lead pencil**. Mark answers clearly, erasing completely any changes. Make no marks outside answer spaces. **Do not skip any questions**, even if you are not absolutely sure. (Marking Example: [ ] [■])

Initials: ___ ___ ___ Last Six Numbers of Social Security No. ___ ___ - ___ ___ ___ ___

Today's Date ___/___/___ Age _____ Sex (mark one) [1] Male [2] Female

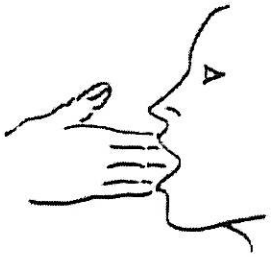
Marital Status (mark one): [1] Single [2] Married [3] Separated [4] Divorced [5] Widowed [6] Remarried

Ethnic/Racial Group (mark one): [1] Black [2] Hispanic [3] Oriental [4] White [5] Other

Number of School Years (mark one): [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] [11] [12] [13] [14] [15] [16] [17] [18] [19] [20+]

Problem Length (mark one): [1] None [2] Less Than 1 Month [3] 1-5 Months [4] 6-11 Months [5] 1-2 Years [6] 3-5 Years [7] 6-10 Years [8] 10+ Years

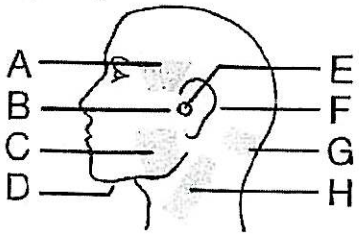
1. This question should only be answered if you have upper and lower front teeth or are wearing a replacement for them. Open your mouth as wide as possible and position your hand as shown in the diagram below. Place as many fingers as possible between your upper and lower front teeth. Now **mark one number** below indicating the **number of fingers.**



(mark one)

less than 1 finger..... [0]
at least 1 finger..... [1]
at least 2 fingers..... [2]
at least 3 fingers..... [3]
at least 4 fingers..... [4]

For questions #2-8 below, locate each area on your face (except F) using the lettered diagram. Press each area firmly on both sides of your face. **Mark the number** that indicates the **maximum amount of pain** you feel.



no pain 0
slight pain 1
moderate pain 2
quite a bit of pain 3
extreme pain 4

(mark one)

2. Pressing my temples (A on diagram)..... [0] [1] [2] [3] [4]
3. Pressing my jaw joints (B on diagram)..... [0] [1] [2] [3] [4]
4. Pressing my jaw muscles (C on diagram)..... [0] [1] [2] [3] [4]
5. Pressing the muscles under the sides of my jaw (D on diagram)..... [0] [1] [2] [3] [4]
6. Pressing in my ears (E on diagram)..... [0] [1] [2] [3] [4]
7. Pressing the back of my neck (G on diagram)..... [0] [1] [2] [3] [4]
8. Pressing the sides of my neck(H on diagram)..... [0] [1] [2] [3] [4]

Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

none of the time	**0**
a little of the time	**1**
a moderate amount of time	**2**
quite a bit of time	**3**
all of the time	**4**

(mark one)

9.	Just a light touch on my face causes shock-like pain.....	[0] [1] [2] [3] [4]
10.	My jaw must click or pop before I can open it wide.....	[0] [1] [2] [3] [4]
11.	My jaw opens all the way without any sideways movements.....	[0] [1] [2] [3] [4]
12.	My jaw locks open.....	[0] [1] [2] [3] [4]
13.	I have headaches which begin after seeing flashes of light or dark spots.....	[0] [1] [2] [3] [4]
14.	My jaw moves easily.....	[0] [1] [2] [3] [4]
15.	I have health problems which haven't responded to treatment.....	[0] [1] [2] [3] [4]
16.	I have pain in my jaw joint(s) (B on the diagram).....	[0] [1] [2] [3] [4]
17.	My jaw tires easily when chewing.....	[0] [1] [2] [3] [4]
18.	I have headaches which are made worse by bright light.....	[0] [1] [2] [3] [4]
19.	It hurts my teeth when I bite.....	[0] [1] [2] [3] [4]
20.	I have muscle or joint pain in areas other than my head or neck.....	[0] [1] [2] [3] [4]
21.	I can move my jaw more to one side than the other.....	[0] [1] [2] [3] [4]
22.	I feel tense and worried.....	[0] [1] [2] [3] [4]
23.	I have drainage from my ear(s).....	[0] [1] [2] [3] [4]
24.	I feel sad and depressed.....	[0] [1] [2] [3] [4]
25.	I clench my teeth.....	[0] [1] [2] [3] [4]
26.	My bite feels comfortable.....	[0] [1] [2] [3] [4]
27.	I have jaw pain which gets worse the more I move my jaw.....	[0] [1] [2] [3] [4]
28.	It is difficult to find a comfortable position for my jaw.....	[0] [1] [2] [3] [4]
29.	I have pain in my ear(s) (E on diagram).....	[0] [1] [2] [3] [4]
30.	I have sinus problems.....	[0] [1] [2] [3] [4]
31.	When I bite down normally, my front teeth touch.....	[0] [1] [2] [3] [4]
32.	During my life, I've had many different painful disorders.....	[0] [1] [2] [3] [4]
33.	I have facial pain which comes on suddenly like electric shocks.....	[0] [1] [2] [3] [4]
34.	I can open my mouth as far as possible without pain.....	[0] [1] [2] [3] [4]
35.	I have pain in or behind my eye(s).....	[0] [1] [2] [3] [4]
36.	My jaw makes a grating or grinding noise when it opens and closes.....	[0] [1] [2] [3] [4]
37.	I think my bite is off.....	[0] [1] [2] [3] [4]
38.	I have pain which gets worse with stress or tension.....	[0] [1] [2] [3] [4]

Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

none of the time	**0**
a little of the time	**1**
a moderate amount of time	**2**
quite a bit of time	**3**
all of the time	**4**

(mark one)

39.	My jaw clicks or pops when I chew.....	[0] [1] [2] [3] [4]
40.	I can bite down hard without pain in my jaw.....	[0] [1] [2] [3] [4]
41.	One painful problem is followed by another.....	[0] [1] [2] [3] [4]
42.	I have jaw pain which makes me feel sick and feverish.....	[0] [1] [2] [3] [4]
43.	I grind my teeth during the day.....	[0] [1] [2] [3] [4]
44.	I have numb areas on my face.....	[0] [1] [2] [3] [4]
45.	I use nerve pills, sleeping pills, or alcohol for relief.....	[0] [1] [2] [3] [4]
46.	I can move my jaw smoothly.....	[0] [1] [2] [3] [4]
47.	I can chew without bumping my teeth unexpectedly.....	[0] [1] [2] [3] [4]
48.	I have a feeling of pins and needles on my face.....	[0] [1] [2] [3] [4]
49.	I have pain in my jaw muscles (C on diagram).....	[0] [1] [2] [3] [4]
50.	I have pain in the back of my neck (G on diagram).....	[0] [1] [2] [3] [4]
51.	Over the years, I've been under a lot of stress.....	[0] [1] [2] [3] [4]
52.	My jaw twitches or jerks uncontrollably.....	[0] [1] [2] [3] [4]
53.	When I bite down normally, my back teeth touch.....	[0] [1] [2] [3] [4]
54.	The way my front teeth fit seems to be changing.....	[0] [1] [2] [3] [4]
55.	A light touch on one side of my face causes shock-like pain on the other.....	[0] [1] [2] [3] [4]
56.	I have a ringing in my ear(s).....	[0] [1] [2] [3] [4]
57.	I have pain which gets worse with certain people or situations.....	[0] [1] [2] [3] [4]
58.	I have pain in the side(s) of my neck (H on diagram).....	[0] [1] [2] [3] [4]
59.	I have a steady pain across my forehead.....	[0] [1] [2] [3] [4]
60.	I have many changing pains.....	[0] [1] [2] [3] [4]
61.	I feel angry.....	[0] [1] [2] [3] [4]
62.	Other people notice noise from my jaw when I chew.....	[0] [1] [2] [3] [4]
63.	I can chew food as well as I used to.....	[0] [1] [2] [3] [4]
64.	I have health problems which seem to be getting worse.....	[0] [1] [2] [3] [4]
65.	I have pain in the muscles under my jaw (D on diagram).....	[0] [1] [2] [3] [4]
66.	I have pain in my temple(s) (A on diagram).....	[0] [1] [2] [3] [4]
67.	I feel anxious.....	[0] [1] [2] [3] [4]
68.	I can open my mouth as wide as I used to.....	[0] [1] [2] [3] [4]

Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

none of the time	**0**
a little of the time	**1**
a moderate amount of time	**2**
quite a bit of time	**3**
all of the time	**4**

(mark one)

69.	The way my back teeth fit seems to be changing.....	[0] [1] [2] [3] [4]
70.	I sleep well.....	[0] [1] [2] [3] [4]
71.	I have head or facial pain which gets worse when I bend over.....	[0] [1] [2] [3] [4]
72.	When I touch one side of my face, the other side gets numb.....	[0] [1] [2] [3] [4]
73.	My jaw gets stuck and won't open all the way.....	[0] [1] [2] [3] [4]
74.	The only real problems in my life are problems with my physical health.....	[0] [1] [2] [3] [4]
75.	I've had conflicting doctors' opinions about health problems.....	[0] [1] [2] [3] [4]
76.	I can move my jaw in any direction without pain.....	[0] [1] [2] [3] [4]
77.	I have facial pain which gets worse in cold weather.....	[0] [1] [2] [3] [4]
78.	I feel frustrated.....	[0] [1] [2] [3] [4]
79.	I have a stuffy nose.....	[0] [1] [2] [3] [4]
80.	Recently I've been under a lot of stress.....	[0] [1] [2] [3] [4]
81.	I have headaches that make me feel sick to my stomach.....	[0] [1] [2] [3] [4]
82.	I can take big bites of things like apples.....	[0] [1] [2] [3] [4]
83.	I have work or family pressures.....	[0] [1] [2] [3] [4]
84.	I have pain and stiffness in my finger joints.....	[0] [1] [2] [3] [4]
85.	My back teeth feel like they fit properly.....	[0] [1] [2] [3] [4]
86.	I believe I have an incurable problem in spite of reassurance by doctors.....	[0] [1] [2] [3] [4]
87.	In the morning my teeth are sore and my jaw is tired.....	[0] [1] [2] [3] [4]
88.	My ears feel blocked or stopped up.....	[0] [1] [2] [3] [4]
89.	I have many health problems.....	[0] [1] [2] [3] [4]
90.	My jaw moves just as far forward as it used to.....	[0] [1] [2] [3] [4]
91.	I have difficulty swallowing.....	[0] [1] [2] [3] [4]
92.	I have pain behind my ear(s) (F on diagram).....	[0] [1] [2] [3] [4]
93.	I have facial pain when other joints are also sore.....	[0] [1] [2] [3] [4]
94.	I have nervous problems.....	[0] [1] [2] [3] [4]
95.	I have throbbing headaches.....	[0] [1] [2] [3] [4]
96.	I feel dizzy.....	[0] [1] [2] [3] [4]
97.	I consider myself to be a sickly person.....	[0] [1] [2] [3] [4]