Facial Problem Questionnaire

General & Cosmetic Care

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I. Name ______________________ Age________

Date __________ Referred by ______________________

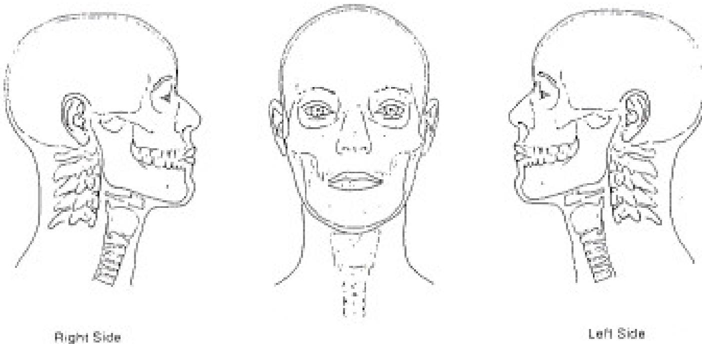
II. Which of the following do you have (circle all that apply)

Headaches Neck Pain Jaw pain Ear Pain

Facial Pain Bite Problems Damaged teeth

Other ______________________

III. Please shade in where your pain is located:



IV. How long have you had this pain? ______________________

Is the pain constant? ______________________

Is the pain (circle all that apply) Aching Burning

Stabbing Sharp Dull Other __________

Is the pain worse in the (circle all that apply)

Morning Afternoon Evening Night

What makes the pain better? ______________________

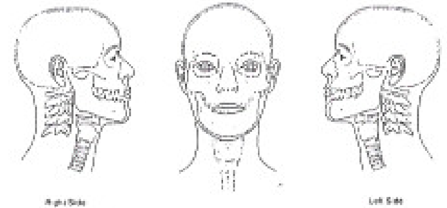
____

What makes the pain worse? ______________________

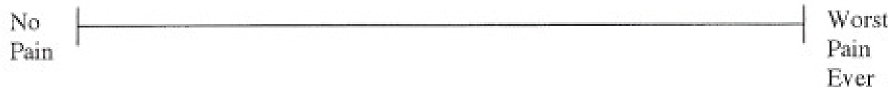
____

Please do not write in this space.

Date ________



How severe is your pain? Please make a mark along the line below:

No Pain  Worst Pain Ever

V. What medication do you take or have you previously taken for your pain?

MEDICATION	DOSE	FREQUENCY
___	___	___
___	___	___
___	___	___
___	___	___
___	___	___

Please do not write in this space.

VI. Does it hurt to move your jaw? Y N

Does it hurt to chew? Y N

Any discomfort upon chewing hard foods like carrots? Y N

Do your jaw muscles get tired from chewing? Y N

Does it hurt to open wide? Y N

Which side of your jaw makes a popping sound? R L

Which side of your jaw makes a clicking noise? R L

Which side of your jaw makes other noises? R L

What Noises? ___

When did you first notice the noises? ___

VII. Have you ever not been able to open your jaw all the way? Y N

Have you ever had to wiggle your jaw to get it open? Y N

Has your jaw ever been stuck open and you could not close it? Y N

When did this first happen? ___

When did this last happen? ___

VIII. Have you noticed a change in the way your teeth come together? Y N

Have you noticed your teeth shifting? Y N

Has the shape of your face changed? Y N

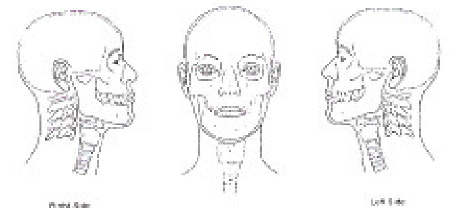
Has your chin shifted to one side of your face? Y N

When did you notice any of the above changes? ___

IX Do you get headaches? Y N How often? ___

How long do they last? ___

Where does it ache? ___



Please do not write in this space.

IX. 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? ____________________

X. Which of the following dental procedures have you had (please circle):

Fillings Orthodontics Root Canal

Crowns Bridges Bite Adjustment

If you had braces, how many times were you in braces? _________

How old were you when you got braces? ___________

How old were you when you were done? ___________

Have you ever had a tooth extracted? Y N

Have you ever split or broken a tooth? Y N

Do you feel there is any connection between the dental work you have had done and the problems you are having? Y N

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

None of the above

(If so please complete the trauma questionnaire)

Do you feel there is any connection between the trauma you have had and the problems you are having? Y N

XII. Do you have problems with your ears? Y N

Dizziness? Y N Ringing? Y N

Hearing? Y N Other? ________________

Is it difficult to swallow? Y N

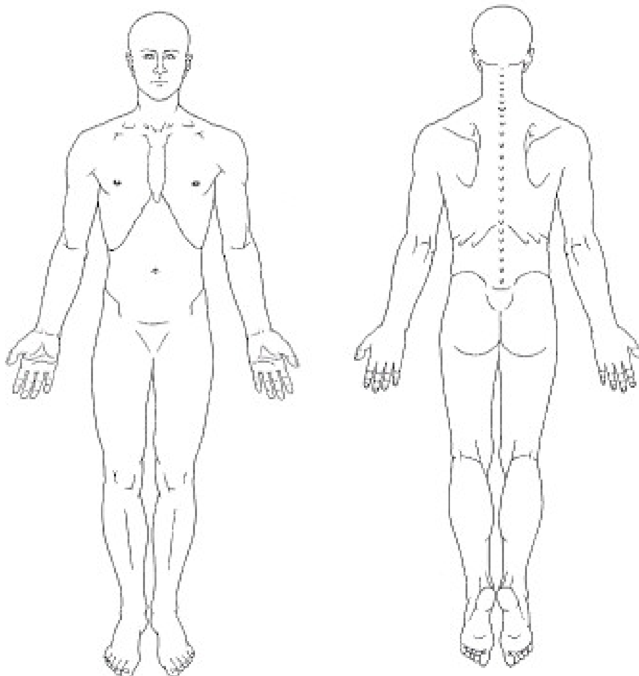
Is it painful to swallow? Y N

Have you noticed any lumps in your face? Y N

Throat? Y N Neck? Y N

XIII.	Have you had any changes in your vision?	Y	N
	Do you get visual disturbances along with headaches?	Y	N
	When was the last time you had your eyes checked? ________		
XIV.	Do you have trouble sleeping?	Y	N
	Do you feel rested when you wake up?	Y	N
	How many hours do you sleep?	________	
	How long does it take you to fall asleep?	________	
	How many times do you awaken during the night?	________	
	Do you consider yourself under a lot of stress?	Y	N
	Do you worry?	Y	N
	Do you ever get depressed?	Y	N
	How often? ______________________________		
	Have you ever had a stomach problem?	Y	N
	Ulcers?	Y	N
	Rate the nutrition of your diet:		
	Excellent Could be better	Poor	
	Do you use vitamin supplements?	Y	N
	Do you exercise?	Y	N
XV.	Do you have or have you had arthritis?	Y	N
	Have you been treated for any other painful condition in the last three years other than your present problem?	Y	N
	Explain ______________________________		

On the diagram below please indicate any other areas that are painful:



Please do not write in this space.

Please do not write in this space.

XVI. Have you had any prior treatment for TMJ problems? Y N

Appliance/Splint? Y N When? __________ Did it help? Y N

Nightguard? Y N When? __________ Did it help? Y N

Bite adjustment? Y N When? __________ Did it help? Y N

Orthodontics? Y N When? __________ Did it help? Y N

Other ____

____

XVII. Please list, in chronological order, health care providers you have seen for this problem:

Date	Doctor or provider	Treatment	Did it help?
______	____________________	__________________	Y N
______	____________________	__________________	Y N
______	____________________	__________________	Y N
______	____________________	__________________	Y N
______	____________________	__________________	Y N
______	____________________	__________________	Y N

XVIII. Describe the problem (s) in your own words:

____

____

____

____

____

____

____

XIX. How have these problems affected your life? Does it keep you from doing anything that you want to do? (work, play, chores, eating, talking)

____

____

____

What would you like to accomplish with treatment here?

____

____

____

XX. Is there anything else that I should know about?

____
____
____
____
____
____
____

XXI. So that I can better understand your pain, please complete the following:

What does your pain feel like? Some of the words below describe your present pain.

Circle all the words that describe it.

Flickering	Jumping	Pricking	Sharp	Pinching
Quivering	Flashing	Boring	Cutting	Pressing
Pulsing	Shooting	Drilling	Lacerating	Gnawing
Throbbing		Stabbing		Cramping
Beating		Lancinating		Crushing
Pounding				
Tugging	Hot	Tingling	Dull	Tender
Pulling	Burning	Itchy	Sore	Taut
Wrenching	Scalding	Smarting	Hurting	Rasping
Searing	Stinging	Aching	Splitting	
			Heavy	
Tiring	Sickening	Fearful	Punishing	Wretched
Exhausting	Suffocating	Frightful	Grueling	Blinding
		Terrifying	Cruel	
		Vicious		
Annoying	Spreading	Tight	Cool	Nagging
Troublesome	Radiating	Numb	Cold	Nauseating
Miserable	Penetrating	Drawn	Freezing	Agonizing
Intense	Piercing	Squeezing		Dreadful
Unbearable		Tearing		Torturing

XXII. I have completed all 6 pages to the best of my knowledge and I personally have filled in each blank in my own writing.

_________________________________ ______________

signature date

Please provide the names and contact information for doctors (Dentists, Medical Doctors, and Therapist) you are currently seeing and those you have seen in the past.

Currently Seeing	No Longer See	Keep them updated with my progress	
❑	❑	❑	Name Phone # E-Mail
❑	❑	❑	Name Phone # E-Mail
❑	❑	❑	Name Phone # E-Mail
❑	❑	❑	Name Phone # E-Mail
❑	❑	❑	Name Phone # E-Mail

Write additional doctors on the back or separate sheet of paper