TMJ – Facial Pain Questionnaire

Name:_____ Referred by:_____ Age:_____ Date:_____

HISTORY

I. Chief Complaint (Describe your problem in your own words):

II. Symptoms Total length of time some or all TMJ/Facial pain symptoms present:_____

Pain: ❑Right ❑Left ❑Both Sides

Location: ❑Temporal Region ❑Cheek Region ❑Lower Jaw ❑Ear
❑TMJ Region (in front of ear) ❑Neck ❑Shoulders ❑Teeth ❑Other_____

Duration/Timing: worse in the ❑Morning ❑Afternoon ❑Evening
❑Constant ❑Intermittent ❑Worse after eating/talking

Joint Noises: ❑*Popping/clicking*: ❑Right ❑Left ❑Bilateral
❑*Grinding:* ❑Right ❑Left ❑Bilateral

Limited mouth opening: ❑Persistent ❑Intermittent ❑Difficulty opening mouth ❑Sleeping
❑Difficulty closing mouth ❑Chewing ❑Yawning or laughing

Jaw locking episodes: ❑Locked open ❑Locked closed How often?_____

Headaches: ❑Right ❑Left ❑Bilateral ❑Frontal (forehead) ❑Temporal (side of head) ❑Occipital (back of head)

Ringing in Ears: ❑Right ❑Left **Fullness in Ears:** ❑Right ❑Left

❑Dizziness ❑Visual Changes ❑Change in hearing

Other_____

III. Possible Contributing Factors

❑Facial Trauma/Injury_____

❑Whiplash/Cervical Trauma_____

❑Bruxism (grinding teeth) **❑Arthritis** **❑Sleep Disorder**_____

❑Stress (1-mild 10-severe) 1 2 3 4 5 6 7 8 9 10

IV. Other Diagnosis and Treatment

❑Panoramic Radiograph ❑TMJ Tomograms ❑MRI of TMJ region

Have you been prescribed a bite splint or night guard? ❑Yes ❑No

If yes, do you use it? ❑Always ❑Occasionally ❑Rarely/Never

Have you tried?

PT ❑Yes ❑No

Massage ❑Yes ❑No

V. Medications

□ Non steroidals (such as Advil, Tylenol, Aleve) How often?_____
□ Muscle Relaxers (such as Flexeril, Soma, Robaxin) How often?_____
□ Sleep Meds/Anti-depressants/Anti-Anxiety? How often?_____
□ Other _____ How often?_____
_____ How often?_____

VI. Previous Treatment

Doctor:_____ Oral Surgeon:_____

Dentist:_____ Others:_____

"Complete Back Side"

1. Put an X on the line to rate your current level of *jaw/headache pain*:

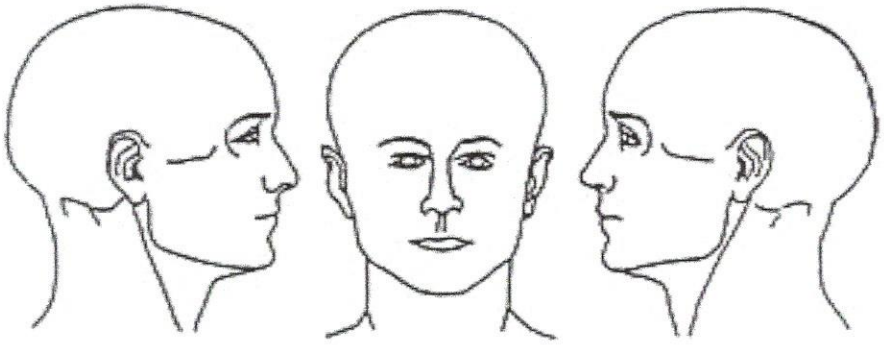
0 ---------- 10 _____
No pain worst pain imaginable

2. Put an X on the line to rate your current level of *neck pain*:

0 ---------- 10 _____
No pain worst pain Imaginable

3. On the diagram below, please shade the areas of your pain:

Right Left



4. Please check medications you are taking for TMJ/facial pain/headaches:

Medication:

☐ Non steroidals (such as Advil, Tylenol, Aleve) How often?_____

☐ Muscle Relaxers (such as Flexeril, Soma, Robaxin) How often?_____

☐ Sleep Meds/Anti-depressants/Anti-Anxiety? How often?_____

☐ Other_____ How often?_____

_____ How often?_____

Name: _____ Date: _____

TMD Disability Index (Steigerwald/Maher)

Please circle the number that corresponds with the one statement that best pertains to you (not necessarily exactly) in each of the following categories.

1. Communication (talking)

0 I can talk as much as I want without pain, fatigue, or discomfort.
1 I can talk as much as I want, but it causes some pain, fatigue and/or discomfort.
2 I can't talk as much as I want because of pain, fatigue and/or discomfort.
3 I can't talk much at all because of pain, fatigue and/or discomfort.
4 Pain prevents me from talking at all.

2. Normal living activities (brushing teeth/flossing).

0 I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort.
1 I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.
2 I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort, jaw tiredness no matter how slow and careful I am.
3 I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
4 I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

3. Normal living activities (eating, chewing).

0 I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
1 I can eat and chew most anything I want, but it sometimes causes some pain/discomfort and/or jaw tiredness.
2 I can't each much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
3 I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
4 I must stay on a liquid diet because of pain and/or restricted opening.

4. Social/recreational activities (singing, playing musical instruments, cheering, laughing, social activities, playing amateur sports/hobbies, and recreation, etc.)

0 I am enjoying a normal social life and/or recreational activities without restriction.
1 I participate in normal social life and/or recreational activities but pain/discomfort is increased.
2 The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instruments, singing).
3 I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
4 I have practically no social life because of pain.

5. Non-specialized jaw activities (yawning, mouth opening and opening my mouth wide).

0 I can yawn in a normal fashion, painlessly.
1 I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
2 I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
3 Yawning and opening my mouth wide are somewhat restricted by pain.
4 I cannot yawn or open my mouth wide more than two finger widths (28-32cm) or, if I can, it always causes greater than moderate pain.

6. Sexual function (including kissing, hugging and any and all sexual activities to which you are accustomed).

0 I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache, face or jaw pain.
1 I am able to engage in all my customary sexual activities and expression, but it sometimes causes some headache, face or jaw pain, or jaw fatigue.
2 I am able to engage in all my customary sexual activities and expression, but it usually causes enough headache, face or jaw pain to markedly interfere with my enjoyment, willingness and satisfaction.
3 I must limit my customary sexual expression and activities because of headache, face or jaw pain or limited mouth opening.
4 I abstain from almost all sexual activities and expression because of the head, face or jaw pain it causes.

7. Sleep (restful, nocturnal sleep pattern).

0 I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
1 I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aids.
2 I fail to realize 6 hours restful sleep even with the use of pills.
3 I fail to realize 4 hours restful sleep even with the use of pills.
4 I fail to realize 2 hours restful sleep even with the use of pills.

8. Effects of any form of treatment, including, but not limited to, medications, in-office therapy, treatments, oral orthotics (e.g. splints, mouthpieces), ice/heat, etc.

0 I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.
1 I can completely control my pain with some form of treatment.
2 I get partial, but significant, relief through some form of treatment.
3 I don't get "a lot of" relief from any form of treatment.
4 There is no form of treatment that helps enough to make me want to continue.

9. Tinnitus, or ringing in the ear(s).

0 I do not experience ringing in my ear(s).
1 I experience ringing in my ear(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
2 I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.
3 I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
4 I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

10. Dizziness (lightheaded, spinning and/or balance disturbances).

0 I do not experience dizziness.
1 I experience dizziness, but it does not interfere with my daily activities.
2 I experience dizziness which interferes somewhat with my daily activities, but I can accomplish my set goals.
3 I experience dizziness which causes a marked impairment in the performance of my daily activities.
4 I experience dizziness which is incapacitating.

Score: _____