Comprehensive TMD Questionnaire

Please complete all questions, as this helps us understand how we can best serve you.

Name _____ Exam Date_____

DOB _____ Gender: - Ethnicity_____

Phone (H) (_____)_____ (W) (_____)_____ (Cell) (____)_____

Email _____

The provider who referred you for this evaluation? _____

Is this evaluation for one of the following: -

Why are you here? Describe your pain or problem(s):

_____

_____

When and how did your pain /problem(s) start?

_____

_____

Who have you seen for your pain problem(s)?

(Hold "Ctrl" key to select multiple)

-
Dentist
Primary Care
Neruology
ENT
Pain Clinic
Physical Therapy
Chiropractic
Other

What treatments and/or medications have you received for this pain problem(s)?

_____

_____

What do you think is wrong or causing your pain/problem(s)? What do you think needs to be done about it?

_____

_____

Why did you decide to seek care at this time?

_____

_____

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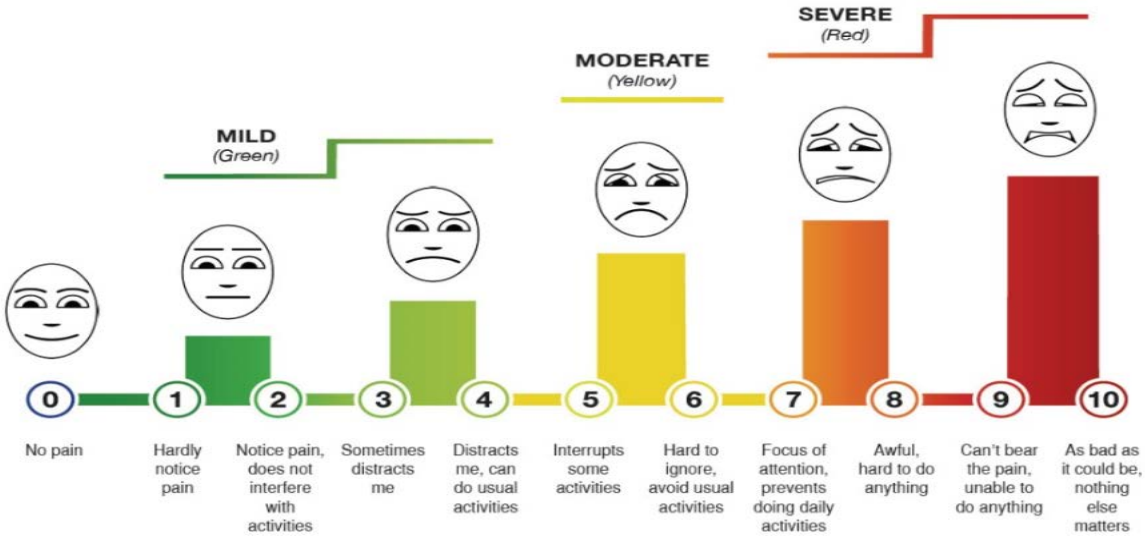


What is your level of pain from <u>the painful area that is the main reason for your visit</u>?

	No discomfort 0	1	2	3	4	5	6	7	8	9	Worst pain imaginable 10
1. **Today**	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
2. **At its Worst**	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
3. **Average**	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Any pain free days? - **When were you last completely pain free**? _____

Check the word(s) that describe your pain or problem(s)?

☐ Sharp ☐ Burning ☐ Electric-like ☐ Aching ☐ Throbbing ☐ Dull ☐ Pulsing ☐ Pressing ☐ Stabbing ☐ Tingling

Please Rate Your Pain Interference:

4. **In the past 7 days, how much has your pain interfered with your general activities?**

No Interference — Unable to perform any activities

0	1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

5. **In the past 7 days, how much has your pain interfered with your enjoyment of life?**

No Interference — Unable to enjoy life

0	1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

6. **In the past 6 months how much has your pain interfered with your ability to work including housework?**

No Interference — Unable to perform any activities

0	1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

7. **About how many days, in the last six months, have you been kept from your usual activities (work, school and/or housework) because of your pain?** _____

8. **What does your pain limit you from doing?**

_____

Pain Modifiers:

What starts your pain? _____

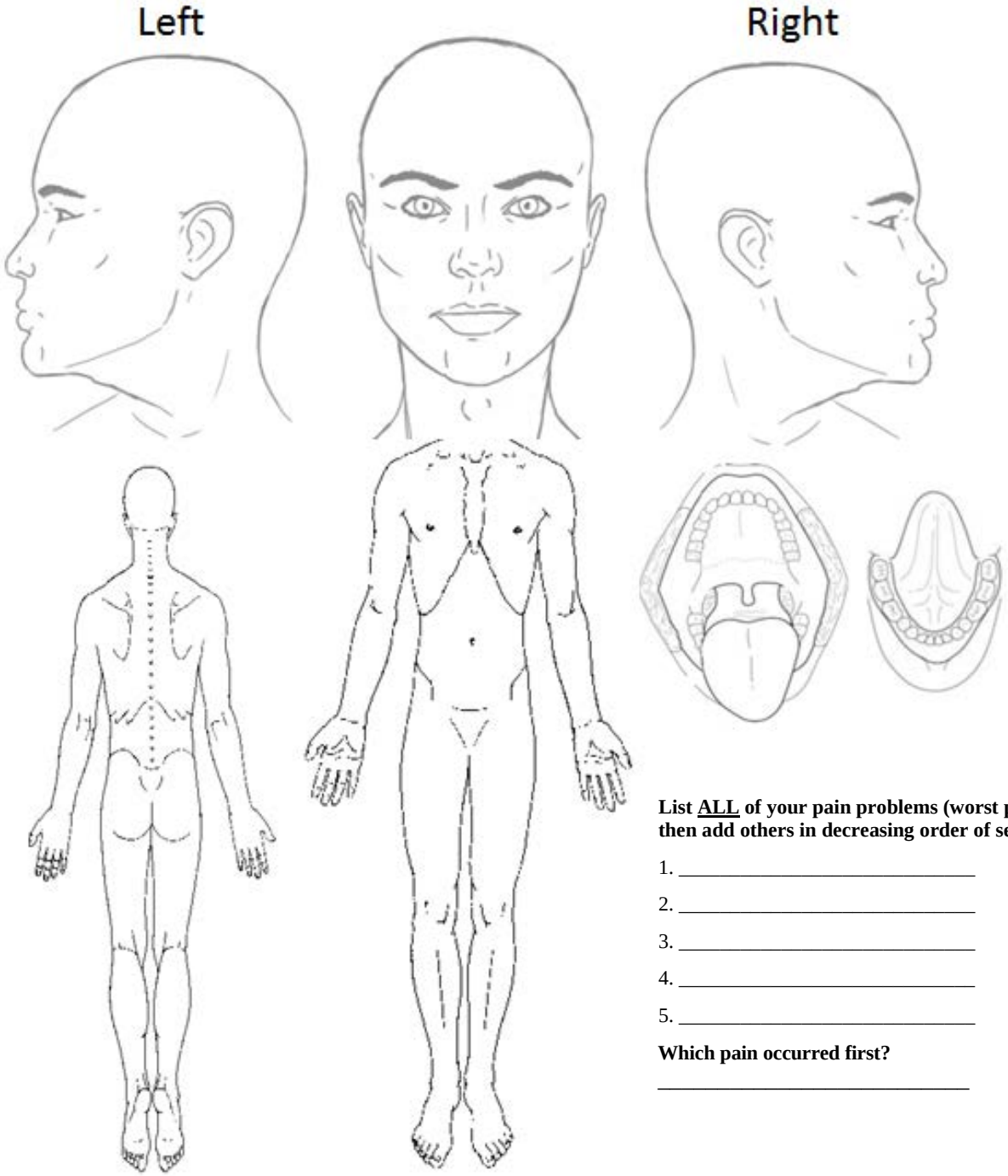
What makes your pain worse? _____

What makes your pain better? _____

Does anything else happen when your pain is present (swelling, change in vision, nausea, etc.)? _____

_____

Outline/draw the location(s) of <u>ANY AND ALL BODY PAIN</u> that you are experiencing.



List <u>ALL</u> of your pain problems (worst pain first then add others in decreasing order of severity):

1. _____
2. _____
3. _____
4. _____
5. _____

Which pain occurred first?

_____

What is your <u>overall</u> level of total body pain?

	No discomfort 0	1	2	3	4	5	6	7	8	9	Worst pain imaginable 10
1. **Today**	○	○	○	○	○	○	○	○	○	○	○
2. **Worst**	○	○	○	○	○	○	○	○	○	○	○
3. **Average**	○	○	○	○	○	○	○	○	○	○	○

Any pain free days? - **When were you last completely pain free?** _____

Medical History

Medical Conditions: _____

_____

Allergies: _____

History of hospitalizations?_____

_____

History of injury or trauma? - _____

Have you ever had a traumatic brain injury (TBI) or a concussion? -

If yes, when? _____ **How did it occur?**_____

If yes, did it happen on a military deployment? -

Current prescription medications: _____

_____

Current non-prescription medications: _____

Herbal/Dietary supplements and Vitamins:_____

History of family medical conditions (headache, fibromyalgia, etc)? _____

Personal Information

Nicotine - How long? _____ cigarettes _____/day cigars ☐ pipe ☐ snuff ☐ vap ☐

Alcohol - beer ____ /day wine _____ glasses/day liquor ____ drinks/day

Caffeine - cups(cans)/day _____ coffee ☐ tea ☐ soda ☐ chocolate ☐ pre-workout ☐ energy drinks ☐

Water - _____ glasses or bottles/day

Do you skip any meals? - **Which?** ☐ Breakfast ☐ Lunch ☐ Dinner

Weight: _____lbs **Height**: ____ft___inches **Neck size**:____inches **Recent weight gain/loss**? -

Exercise level: - **Any activity limitations?**

Type of exercise _____ **Frequency**_____ **Duration** _____

Please estimate how many hours a day (0 to 24 hours) that your teeth touch in any contact _____

What is your typical tongue position? -

Do you clench or grind your teeth? -

If yes, how do you know? ☐ self-aware ☐ told by dentist ☐ told by others

Oral Habits? ☐ bite your nails ☐ chew gum ☐ protrude jaw ☐ other habits

_____

Please rate your levels of:

	None 0	1	2	3	4	5	6	7	8	9	Worst possible 10
Stress	○	○	○	○	○	○	○	○	○	○	○
Anxiety	○	○	○	○	○	○	○	○	○	○	○
Depression	○	○	○	○	○	○	○	○	○	○	○
Anger	○	○	○	○	○	○	○	○	○	○	○

Have you ever thought of harming yourself? - **Is this current?** -

Personal/Family History

Occupation: _____

Marital status:

Children: If yes, list ages _____

Are there any special needs or circumstances involving you, your family members or your job?

_____

_____

Do you have a history of the following or similarly threatening, stressful or frightening life events? -

Abuse - at any age (physical, emotional or sexual), childhood neglect, physical or sexual assault, motor vehicle accident, deployment to a conflict zone, panic attacks, near drowning, other _____

_____

_____

_____

Have you been told that you have post-traumatic stress symptoms (PTSS) or disorder (PTSD)? -

If yes, when?_____

Do you have social/home support? - If yes, whom? _____

Did you grow up religious? - If yes, are you still practicing? _____

Do you have unforgiveness/bitterness towards anyone? _____

Headaches

Do you have problems with headaches? - **For how long?** _____

Family history of headaches?

Do you have more than one kind of headache? - **If yes, how many kinds?**_____

Please describe each type of headache you experience.

	#1	#2	#3
Where on your head does the headache occur?			
Average pain level 0 (no pain) to 10 (worst ever)			
How often do they occur? (daily, weekly, monthly)			
When do they occur? (morning, evening, etc.)			
How long do they last? (secs, mins, hours, days)			
What starts (triggers) your headache?			

With a headache, do you experience? (select all that apply)

-
(Hold "Ctrl" key to select multiple)

Nausea
Vomitting
Light Sensitivity
Sound Sensitivity
Aura
Change in vision
Other

Do you experience any of the following?

Neck pain? - **Neck sounds?** -

If yes, when did it start? _____ **When is it the worst?** _____

Pain from areas below your shoulders? - If yes, where? _____

Dizziness or lightheadedness? - _____

Ear problems? ☐ fullness ☐ stuffiness ☐ ringing ☐ sounds ☐ pain

Numbness or tingling? ☐ around mouth ☐ head/face ☐ arms/fingers ☐ legs/toes ☐ other

Jaw pain? - _____

Tooth pain? - _____

Changes in your bite? - _____

Altered jaw movement(s)? - _____

Jaw joint (TMJ) sounds? - **If yes, is it?** ☐ popping ☐ clicking ☐ grating/grinding ☐ other

Did jaw joint (TMJ) sounds begin before your pain started? -

Have there been any changes in the jaw sounds? _____

If you have jaw pain or stiffness, when is it the worst? -

Does your jaw problem affect your ability to eat? -

Sleep History

How many hours do you sleep? Average night _____Good night _____ Bad night _____

How long does it take to fall asleep? Average night _____Good night _____Bad night _____

Do you awaken at night? - **If so, how many times?_____**

Do you have a regular/consistent sleep schedule? - **Hours** _____ to_____

Do you snore or have a history of sleep apnea? - **Diagnosis Date: _____**

Do you sleep using a CPAP &/or an oral device for sleep apnea? - **Type: _____**

Is your obstructive sleep apnea -

What position do you fall asleep in? -

Do you have problems with nightmares? - **If yes, are they recurring?** -

What are the words that best describe your sleep? -

Do you consider your sleep to be restful or restorative? -

Please check the most appropriate box concerning your sleep during the last 4 weeks.

	No, not in last 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4times a week	Yes, 5 or more times a week
Did you have trouble falling asleep?	☐	☐	☐	☐	☐
Did you wake up several times a night?	☐	☐	☐	☐	☐
Did you wake up earlier than you planned?	☐	☐	☐	☐	☐
Did you have trouble getting back to sleep after you woke up too early?	☐	☐	☐	☐	☐

Please list any additional information that you feel is important for us to know about you, your pain complaint or other aspects of your visit.

_____

_____

_____

_____

RESET FORM