

HEADACHE AND TEMPOROMANDIBULAR JOINT (TMJ) HISTORY QUESTIONNAIRE

Patient Name _____ Age _____ Date _____
Referred by _____ Dentist _____

1. Which do you suffer from most? Headaches____, Neckaches____, Jaw pain____
Facial pain____, Other_____
 2. Where do you get them? Right side____, Left side____, Both sides____,
 3. How long have you had this pain? _____
 4. How frequently? Daily____, Weekly____, Monthly____, Occasionally____
 5. Do you wake up with them? _____.
 6. Do they develop during the day? _____.
 7. Are they worse in the morning? _____, Afternoon____, Evening_____.
 8. On a scale of 1-10, with 10 being the worst pain imaginable, above the shoulders, how many mornings per week do you wake up with a "0"(zero)? _____.
 9. On a scale of 1-10, what is the average "number" you usually wake up with?

 10. What % of your *waking* time do you have some degree of headache? _____
 11. What % of your *waking* time do you have a "0"(zero) without taking medications? _____.
 12. What is your average headache pain level (1-10 scale) throughout the day?
_____.
 13. On a scale of 1-10, what is the worst pain level you experience? _____.
 14. What time of day do you usually experience you worst headaches? _____.
 15. How many times per week(or month) might you experience your worst pain? _____.
 16. Where does your pain seem to originate? _____.
 17. How would you describe your pain? (examples: throbbing, squeezing, pressure, dull, stabbing, shooting, and so on)_____
 18. Please circle the types of health care providers you've seen for your headaches.
MD, Neurologist, ENT, Internist, Physical Therapist, Chiropractor,
Dentist, others:_____
 19. What medical tests have been performed regarding your headaches?
CT Scan, MRI, X-rays, blood analysis, others: _____
 20. What types of procedures or treatment (including dental) have you had regarding your headaches? _____
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21. What medication(s) do you now take to prevent your headaches? _____

22. What medication(s) have you tried to prevent your headaches? _____

23. What prescriptions or over-the-counter medications do you take to relieve your headaches? (and how much) _____
24. Do you clench or grind your teeth? ___ Day? ___, Night? ___ Both? ___
25. Does it hurt to chew hard foods? ___ Yawn? ___ Talk? ___ Open wide? ___, Swallow? ___
26. Do you have problems with your ears? ___ Ringing? ___ Hearing loss? ___ Rushing sounds? ___, Dizziness? ___, Other? _____
27. Do your jaws “click”? ___, “pop”? ___, or make a grating sound? _____
28. How long have you noticed this? _____ Right side? ___ Left side? _____
29. Has your jaw ever locked closed or become stuck momentarily, or longer? ___ When did this first happen? _____ How many times has this occurred? ___ Could you unlock it? ___ How did you unlock it? _____
30. Do you sleep on your back? ___, your right side? ___, your left side? ___ Or your stomach? ___ Most of the time?
31. Is there any stress in your life (job, home, marital, children, and so on)? Please explain _____
32. Any information that you would like to add? _____

Shade in the areas below where you experience you discomfort

