Energy Square Prosthodontics / Central Alberta Prosthodontics

Registered Specialists in Prosthodontics and Restorative Dentistry

Questionnaire for Temporomandibular Disorders

Patient Name

Describe (in your own words) the nature and location of any head or neck pain:

Do you suffer from frequent headaches?	Y	N
Are you aware of an uncomfortable bite?	Y	N
Does your jaw make noise so that it bothers you or others?	Y	N
Do you grind your teeth at night?	Y	N
Does your jaw get stuck so that you can't open freely?	Y	N
Does it hurt when you chew or open wide to take a big bite?	Y	N
Do you have pain in the face, cheeks, jaws, throat or temples?	Y	N
Does your jaw "feel tired" after a big meal or dental visit?	Y	N
Do you have earaches or pain in front of the ears?	Y	N
Do you chew exclusively on one side?	Y	N
Have you had a blow to the jaw (trauma)?	Y	N
Do you grind your teeth at night?	Y	N
Are you a habitual gum-chewer or pipesmoker?	Y	N
Do you have a habit of clamping, clenching, or "setting" your teeth?	Y	N
Do you have any jaw symptoms or headaches upon waking in the morning?	Y	N
Does the pain or discomfort interfere with your daily routine or other activities?	Y	N
Do you take medication or pills for pain or discomfort?	Y	N
Does the pain or discomfort affect your appetite?	Y	N
Do you find the pain or discomfort extremely frustration or depressing?	Y	N
Do you suffer from arthritis or pain in other joints?	Y	N
Do you suffer from nervous stomach or ulcers?	Y	N
Do you suffer from constipation? Irritated bowel syndrome?	Y	N
Do you suffer from back or neck pain (whiplash)?	Y	N
Do you suffer from skin problems or allergies?	Y	N
Have you ever been treated for a jaw muscles or jaw joint disorder?	Y	N
Are you under the care of a chiropractor, physiotherapist or massage therapist?	Y	N

How would your rate your facial pain on a 0-10 scale <u>right now</u>?	
In the past 6 months, how intense was your <u>worst</u> pain on a 0 to 10 scale?	
In the past 6 months, <u>on the average</u>, how intense was your pain?	
In the past 6 months, how much has facial pain interfered with your daily activities rated on a 0 to 10 scale, where 0 is no interference and 10 unable to do any activity?	
In the past 6 months, how much has facial pain changed your ability to take part in recreational, social, family activities, where 0 is no change, and 10 is extreme change?	
In the past 6 months, how much has facial pain changed your ability to work (including housework) where 0 is no change and 10 is extreme change?	
About how many days in the last 6 months have you been kept from your usual activities (work, school, or housework) because of facial pain?	

Notes

Date | Patient or Guardian's Signature | Dentist's Signature