ELLIS K. LIST, D.D.S., P.A.
COMPREHENSIVE & ESTHETIC DENTISTRY

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TMJ/FACIAL PAIN QUESTIONAIRE

Name: _____ Age: _____ Date: _____

Describe your problem _____

_____

_____

How long has it been present? _____

Does the pain/problem limit your function? NO YES

If so, how? _____

Was there any event which you believe may have helped cause the pain/problem?

If so, please describe: _____

Date of Accident: _____ Kind of Accident: _____

Surgery: _____ Dental Treatment: _____

Stress: _____ Other: _____

What other doctors for healthcare associates have you seen regarding this pain/problem?

_____

Describe the treatment you have had for this pain/problem.

Medicines: _____

Physical Therapy: _____

Occlusal Adjustments: _____

Splints: _____ How many? _____

Orthontics: _____

Surgery: _____

Counseling: _____

Other: _____

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Which side hurts RIGHT LEFT BOTH NEITHER

Is the pain: CONSTANT INTERMITTENT

When is the pain worse? MORNING AFTERNOON EVENING

Does anything you do make the pain worse? NO YES
If yes, what? _____

Does anything you do make the pain better? NO YES
If yes, what? _____

Does it hurt to move your jaw? NO YES Does it hurt to chew? NO YES

Do you have, or have you had, any of the following?

Sinus Problems	Migraines	Headaches	Depression
Stressful Job	Neck Ache	Sensitive Teeth	Trouble Sleeping
Arthritis	Home Stress	Shoulder Pain	Periodontal Disease
Ringing in ears	Dizziness	Hearing Changes	Marital Problems
Ulcers	Skin Diseases	Ear Aches	Nervous Stomach

Allergies _____ Other Medical Problems _____

Does your joint/jaw make noise? NO YES Has it ever? NO YES
Do you hear a Click? NO YES Can you hear it Grind? NO YES
When? _____ For how long? _____

Does your jaw ever lock open? NO YES Lock closed? NO YES
How has this been treated? _____
What can you do anything to prevent or treat this? _____

Do you grit or grind your teeth? NO YES

On the scales mark below, mark where your pain falls:
Most of the time, with a line (/)
At its worst, with a circle (o)
At its best or least, with an X

0_____25_____50_____75_____100
No pain Worst Pain

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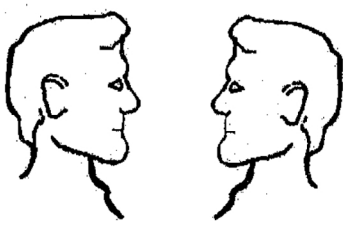
The pain is having this effect on my life:

0	25	50	75	100
No effect	Slight Can play/work am aware	Moderate Some days cannot function	Severe Most days cannot function	Cannot Function at all

Daw an outline and shade the areas of your pain.

R  L

Circle from the list below those words which best describe your pain:

Pulsing	jumping	pricking	sharp	pinching	tugging	cruel
Burning	throbbing	flashing	boring	cutting	cramping	dull
Wrenching	scalding	pounding	shooting	stabbing	lacerating	mild
Crushing	searing	tingling	tender	tiring	sickening	horrible
Fearful	punishing	smarting	aching	stinging	exhausting	intense
Suffocating	frightful	terrifying	splitting	killing	wretched	blinding
Annoying	distressful	miserable	excruciating	unbearable		

Are there any additional comments you would like to make?_____

_____

_____

_____

_____

_____

_____