TMJ/FACIAL PAIN QUESTIONNAIRE

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? _____
Orthotics: _____
Orthodontics: _____
Surgery: _____
Counseling: _____
Other: _____