Dr. Ken Lawrence
Specialist in Orthodontics

Child, Adolescent and Adult Orthodontics
Temporomandibular (TMJ) Disorders
And Related Orofacial Pains

PAIN QUESTIONNAIRE

Date_____

Patient Name_____
Last First Middle

Address_____ Telephone No. (Home)_____

City_____ State_____ Zip_____ (Office)_____

Age _____ Sex: Male_____ Female_____

Marital Status:

____ Married ____ Divorced ____ Separated
____ Single ____ Cohabit ____ Widow/Widower

Number of children_____; Ages_____

Are you presently employed? _____Yes _____No

Occupation _____

Who referred you to our office? _____

Address and telephone _____

****

1. Chief complaint (What problem brings you to this office?)

_____

2. When did you first experience this problem?
(Please describe the circumstance.)

_____

_____

3. How long have you had this problem?
(Number of) ____Years; ____Months; ____Weeks; ____Days

8857 Mentor Avenue
Mentor, Ohio 44060
974-2040
Fax: 974-0305

4. What is the usual severity of your pain?
(Circle the appropriate number)

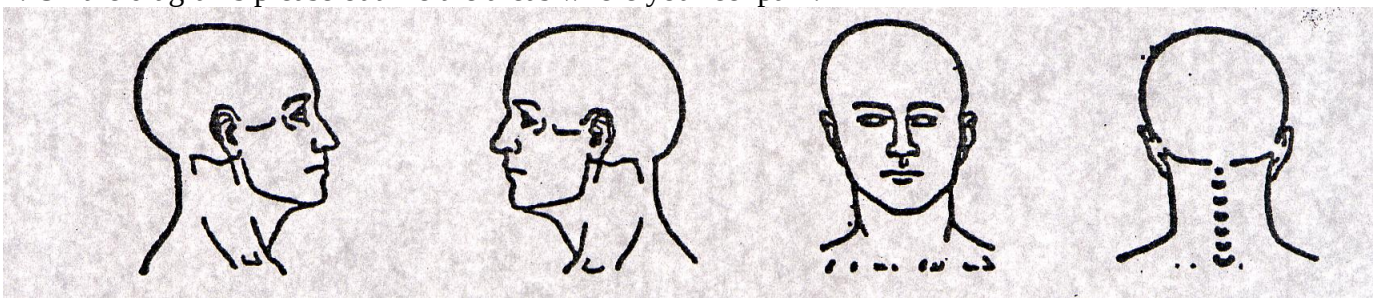
0	1	2	3	4	5	6	7	8	9	10

5. Describe the way your pain feels:

____Throbbing	____ Pressure	____ Drawing
____ Aching	____ Tightness	____ Splitting
____ Shooting	____ Tension	____ Tiring-Exhausting
____ Stabbing	____ Heavy	____ Sickening
____ Sharp	____ Dull	____ Gnawing
____ Burning	____ Tender	____ Cramping
		____ Boring

6. Does the pain seen to radiate, travel, or move from the area of initial pain?
____Yes ____No
____ Pain moves up the side of the head
____ Pain moves around the back of the head
____ Pain moves down the neck
____ Pain moves into the jaw or face
____ Other; Describe_____

7. On the diagrams please outline the areas where you feel pain:



8. When do you have pain?
____Constantly
____Frequently but not predictably
____Occasionally
____No real pattern

9. How long does the pain last?

____Less than 1 minute	____6-12 hours
____1-10 minutes	____ 13-24 hours
____Less than 1 hour	____ Several days
____1-5 hours	____ Constant

10. Do you have numbness or unusual feeling or sensations in your face or jaw?
____No ____Yes If yes, describe_____

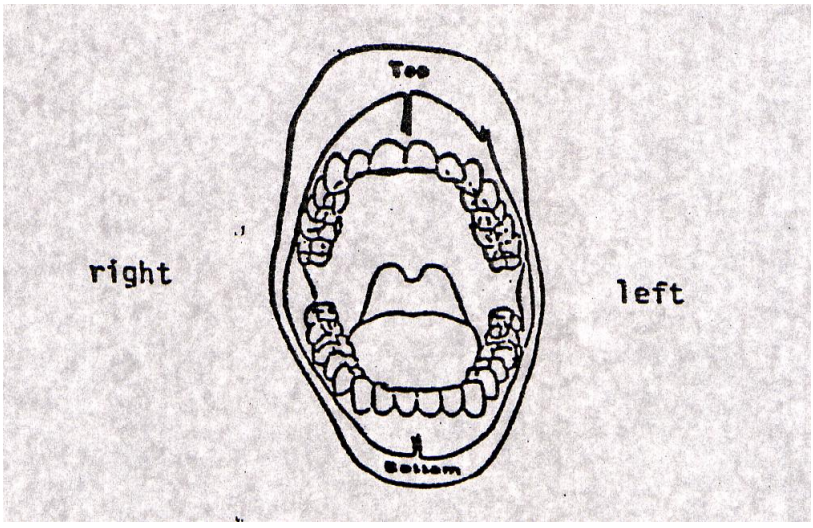
11. Which of the following causes or aggravates the pain?

____Chewing
____Opening mouth wide
____Talking
____Playing musical instrument
____Yawning
____Laughing
____Singing
____Eating certain foods
____Hot of cold foods/drinks
____Damp or cold weather
____Lack of sleep
____Stress or emotional upset
____Riding in a car for long periods
____Exercise
____Other _____

12. Which of the following relieves the pain?

____Massage of the area
____Warm soaks or compressed
____Holding jaw in certain positions
____Pain medication
____Moving or manipulation jaw
____Heat
____Exercise
____Ice or cold compresses
____Sleep
____Time
____Relaxation
____Nothing helps

13. Do you have teeth that hurt or ache?
____No ____Yes If yes, please circle which one(s) on the diagram:



14. Do you have any painful areas in or around your mouth?
____No ____Yes If yes describe_____

15. Do you have pain in your face or jaw?
____No ____Yes If yes, which side? ____Right ____Left

16. Do you have problems with your ears?
____Yes ____No; Which side? ____Right; ____Left

If yes, which of the following?
____Pain ____Buzzing ____Ringing ____Stuffiness
Other_____

17. Are you bothered by dizziness or dizzy spells? ____Yes ____No

18. Do you have pain in the temple or above the ear? ____Yes ____No

19. Do you wake up with a headache? ____Yes ____No

20. Do you have headaches later in the day? ____Yes ____No

21. Do you have headaches as often as once per week? ____Yes ____No

22. Is there any nausea or vomiting associated with your headaches? ____Yes ____No

23. Are there vision changes associated with your headaches? ____Yes ____No

24. Do you take any medication for the headache pain? ____Yes ____No

25. What relieves the headache?
____Pain medication ____Rest ____Nothing
____Sleep ____Exercise
Other_____

26. Do you have pain in your neck? ____Yes ____No

27. Do you have pain in the back of your head? ____Yes ____No

28. Do you have pain in your back? ____Yes ____No

29. Do you have pain, Numbness or tingling in your arms, hands or fingers? ____Yes ____No

30. Do you feel stiff or sore when you wake up in the morning? ____Yes ____No

31. Do you have aches and pains all over your body? ____Yes ____No

32. Do you tire or fatigue easily? ____Yes ____No

33. Have you ever been in an accident or received a “blow” or injury to any part of your face, head, neck, or back? ____Yes ____No If yes, when?_____

34. Are you aware of your jaw making sounds? ____Yes ____No
If yes, please answer the following:

Which side? ____Right ____Left ____Both sides

Describe the nature of the sound:
____Clicking ____Popping
____Grating ____Cracking
Other_____

When do you notice the sound?
____Early opening ____Moving jaw to the side
____Middle opening ____Chewing
____Wide opening ____While closing

Is the sound always present? ____Yes ____No

Does the pain seen to be caused by the sound? ____Yes ____No ____Sometimes

35. Has your jaw ever locked open? ____Yes ____No
____Right side ____Left side ____Both sides

Date of first occurrence_____
If so, can you replace the jaw to normal position yourself? ____Yes ____No

36. Has your jaw ever locked closed or partially closed? ____Yes ____No
____Right side ____Left side ____Both sides

37. How many times has you jaw locked open or closed during the past year? _____

38. Do you have pain when your jaw locks open or closed? ____Yes ____No

39. Have you noticed any decrease in how far you can open your mouth? ____Yes ____No

40. When you open y our mouth, does something in your jaw joint feel like it is in the way?
____Yes ____No

Which side? ____Right ____Left ____Both

41. Do you need to move your jaw from side to side or forward to enable you to open or close your mouth?
____Yes ____No

Which side? ____Right ____Left ____Both

42. Have you ever had braces on your teeth? ____Yes ____No
If yes, when?_____

43. Do you chew gum? ____Yes ____No If yes, how much?
____0-25% of waking hours ____50-75% of waking hours
____25-50% of waking hours ____75-100% of waking hours

44. Have you noticed any other oral habits or practices that aggravate or cause pain? (Chewing ice, chewing finger nails, biting pencils, etc.)
____Yes ____No If yes, what?_____

45. Do you clench or grind your teeth? ____Yes ____No
When? ____Under tension ____While sleeping
Other_____

46. Do you feel that clenching or grinding your teeth causes or contributes to your pain?
____Yes ____No ____Sometimes

47. Do you feel that you are under stress much of the time? ____Yes ____No ____Occasionally

48. Does increased stress seem to make the pain problem worse? ____Yes ____No ____Occasionally

49. Do you get any type of regular exercise? ____Yes ____No

50. Do you enjoy your job? ____Yes ____No

51. Do you feel that you eat a healthful, balanced diet? ____Yes ____No

52. For each of the beverages listed below, write in the average number you drink each day:
Natural coffee_____cups/day
Decaffeinated coffee_____cups/day
Tea_____cups/day
Carbonated soft drinks_____can or bottles/day

53. Does your pain prevent you from performing your normal daily activities? ____Yes ____No

54. Do you have times when you feel as though you can't breathe in enough air? ____Yes ____No
If yes, please explain
_____

55. Do you notice that you hands and feet are often cold or hard to keep warm? ____Yes ____No

56. Have your interest in sexual activities decreased since you have been experiencing pain?
____Yes ____No

57. Do you feel sad or depressed much of the time? ____Yes ____No

58. Have you experienced any of the following:

____Divorced
____Moving
____Re-marriage
____Serious illness of friend or loved one
____Death of friend or loved one
____Job dissatisfaction
____Being fired
____Job changed
____Separation from spouse
____Abuse, physical or sexual
____Problems with children
____Chemical dependency
____ Other_____

59. Are you presently, or have you ever been under the care of a psychiatrist or a psychologist?
____Yes ____No

60. Do you sleep well? ____Yes ____No

61. Do you awaken frequently during the night? ____Yes ____No

62. Are you a restless sleeper? ____Yes ____No

63. Do you have vivid dreams or nightmares? ____Yes ____No

64. Do you go to bed more tired that your daily activities justify? ____Yes ____No

65. Do you feel rested when you get up in the morning? ____Yes ____No

66. What type of health care providers have you seen for your problem?

____None
____General Dentist
____Dental Specialist
Type_____
____Family Physician
____ENT Physician
____Neurologist; neurosurgeon
____Other_____
____Rheumatologist
____Rehabilitation medicine, physical medicine
____Pain clinic
____Osteopathic Physician
____Chiropractor
____Physical Therapist

67. Please list the names of the above health care providers:

_____

_____

_____

68. Please describe the treatment which you have received for your pain:

_____

_____

_____

_____

MEDICAL HISTORY

Please check the box for any condition which you have had in the past or have now:

(1) CARDIOVASCULAR

☐ Heart Failure
☐ Heart Disease or Attack
☐ Angina Pectoris or Chest Pain
☐ High Blood Pressure
☐ Heart Murmur
☐ Rheumatic Fever
☐ Congenital Heart Defect or Lesion
☐ Artificial Heart Valve
☐ Heart Pacemaker
☐ Heart Surgery or Transplant
☐ Other Heart Problems
☐ Stroke
☐ Aneurysm

(2) HEMATOLOGIC

☐ Blood Transfusion
☐ Anemia
☐ Hemophilia
☐ Leukemia
☐ Sickle Cell (Anemia) Disease
☐ Tendency to Bleed Longer than Normal

(3) NEURAL/SENSORY

☐ Eye Pain
☐ Vision Problems
☐ Glaucoma or Cataract in Earaches, Ringing in Ears
☐ Hearing Loss
☐ Severe Headaches
☐ Fainting or Dizzy Spells
☐ Epilepsy, Seizures or Convulsions
☐ Nervousness
☐ Psychiatric Treatment

(4) GASTROINTESTINAL

☐ Stomach/Intestinal
☐ Ulcers
☐ Gastritis
☐ Colitis
☐ Persistent Diarrhea
☐ Hepatitis Liver Disease
☐ Yellow Jaundice
☐ Cirrhosis

(5) RESPIRATORY

☐ Hay Fever
☐ Sinus Trouble
☐ Allergies or Hives
☐ Asthma
☐ Chronic Cough
☐ Emphysema
☐ Tuberculosis (TB)
☐ Breathing Difficulties

(6) DERMAL/MC/MS

☐ Skin Rash
☐ Dark Mole(s) (recent changes in appearance)
☐ Night Sweats
☐ Sore Muscles
☐ Stiff Joints
☐ Arthritis
☐ Artificial Joint
☐ Fever Blister
☐ Mouth Ulcers or Cancer Sores
☐ Colored or Discolored Areas in Mouth

(7) ENDOCRINE

☐ Diabetes
☐ Thyroid Disease

(8) URINARY/ST

☐ Urinate Frequently
☐ Kidney, Bladder Problem
☐ Sexually Transmitted Disease (Syphilis, Gonorrhea, Chlamydia or Genital Herpes)
☐ HIV Positive
☐ AIDS Related Complex
☐ Acquired Immunodeficiency Syndrome

(9) OTHER CONDITIONS

☐ Frequent Sore Throats
☐ Enlarged Lymph Node or "Gland"
☐ Use Tobacco
☐ Use Alcohol
☐ Drug Addiction
☐ Tumor or Cancer
☐ X-ray or Cobalt Treatment
☐ Chemotherapy
☐ Disease, Problem or Condition Not Listed
If yes, list

_____
_____
_____
_____
_____
_____