# Pre-Treatment Questionnaire

Name_____ Date of birth _____ today's date _____
Gender M / F Occupation _____

Please complete this questionnaire by answering all questions as accurately and honestly as possible. This will help us to gather important information which may be contributing to your condition. Some questions may seem strange or not applicable to you, but there is a specific reason for each one. Your confidentiality will be respected. Thank you very much.

What is your primary goal in seeking treatment here?

_____

_____

_____

Chief Complaint:

- ❑ Tooth pain ____
- ❑ Face pain ___
- ❑ Jaw pain _____
- ❑ Headache _____
- ❑ Neck ache _____
- ❑ Jaw joint clicks or pops _____
- ❑ Can't open wide _____
- ❑ Appearance of face or teeth _____
- ❑ Bite feels uncomfortable or unusual _____
- ❑ Jaw locks, gets stuck or goes out _____
- ❑ Other (Please describe) _____

_____

If you could rank each complaint on a scale of 1 to 10, what number would you assign them? (Write number in space next to each item, 1= no pain at all and 10= worst possible pain)

How long ago did you notice the above problem?

- ❑ Less than 4 weeks
- ❑ 1-6 months
- ❑ 6-12 months
- ❑ 1-2 years
- ❑ 2-5 years
- ❑ Over 5 years

If you have pain or joint noises, how frequent are the symptoms?

- ❑ More than 1x a day
- ❑ 1x a day
- ❑ 3x a week
- ❑ 1x a week
- ❑ 2x a month
- ❑ Less than 3x a year

If you have acute chronic pain, what do *YOU* think is the cause of your pain?

_____

_____

Please list all practitioners you have consulted about this condition, and whether treatment was rendered.

| Date last seen | Physician | Specialty | Seen for symptoms | Type of treatment recommended |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please list any physicians you are seeing **currently** for the above problem

| Date last seen | Physician | Specialty | Seen for symptoms | Type of treatment given |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

List all treatments you have had for this condition in the **past** (please list in chronological order beginning with the earliest treatment – you may add additional sheets if necessary):

| Date | Physician | Specialty | Location | Treatment |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**If you have pain, answer the rest of the questions on this page.**

Under what circumstances did the symptoms begin? (Please check all that apply)

- ❑ Accident at work
- ❑ Accident at home
- ❑ Other accident
- ❑ At work, but not an accident
- ❑ Following surgery
- ❑ Following illness
- ❑ Pain just began, can't relate it to anything
- ❑ Other _____

With regard to these conditions, are you presently involved with any litigation? ❑ Yes ❑ No

Did the symptoms start after any of the following conditions?

❑ INJURY
- ❑ To head
- ❑ To neck
- ❑ To jaw
- ❑ To back
- ❑ Other _____

❑ DENTAL TREATMENT
- ❑ Orthodontics
- ❑ Grinding on teeth
- ❑ Irregular or raised dental filling
- ❑ Other _____

❑ OTHER
- ❑ Excessively large bite/yawn
- ❑ Chewing food
- ❑ Cervical traction
- ❑ Emotional upset
- ❑ Other _____

Please check any of the following words, which describe your pain:

- ❑ Dull
- ❑ Sharp
- ❑ Mild
- ❑ Moderate
- ❑ Severe
- ❑ Aching
- ❑ Burning
- ❑ Pulsating
- ❑ Spreading
- ❑ Pressure, Drawing, or Pulling
- ❑ Constant
- ❑ Intermittent
- ❑ Stops Suddenly
- ❑ Stops Gradually
- ❑ Annoying
- ❑ Troublesome
- ❑ Miserable
- ❑ Intense
- ❑ Unbearable
- ❑ Superficial
- ❑ Deep

Signature _____

Where is the pain located?

- ❑ Frontal (forehead)
- ❑ Temporal (temple)
- ❑ Auricular (ear)
- ❑ Cheek area
- ❑ Pre-auricular (front of ear)
- ❑ Occipital (back of head)
- ❑ Lateral cervical (neck)
- ❑ Mandibular (angle of jaw)
- ❑ Retro-orbital (back of eyes)

**CHECK ALL THAT MAY APPLY, AND CIRCLE WHERE CHOICES ARE OFFERED**

- ❑ Anything trigger your pain? Yawn, Chew, Cold, Other _____
- ❑ Anyone else in your family with Head/Dental pain problems
- ❑ Sensitive teeth
- ❑ Popping, grinding or clicking in your jaw
- ❑ Popping, grinding or clicking in your neck
- ❑ Difficulty when opening
- ❑ Pain when opening your jaw
- ❑ Pain when chewing

**Do you have any of these signs or symptoms?**

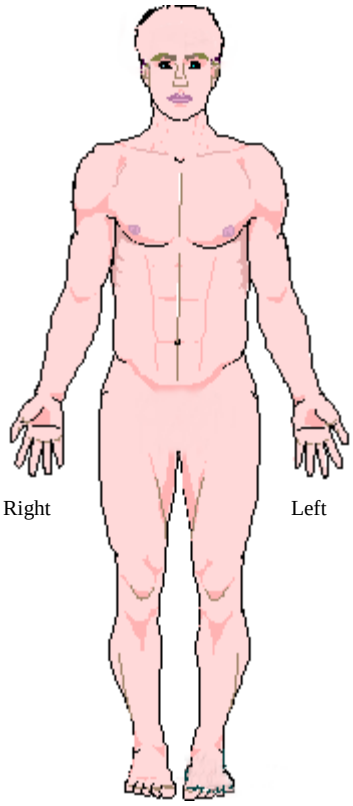
- ❑ Bruxing (clenching of teeth)? Day, Night
- ❑ Parasthesia (numbness) Where? _____
- ❑ Tinnitus (ringing in your ears)
- ❑ Stuffiness in your ears (clogged ears)
- ❑ Vertigo (dizziness)
- ❑ Depression anxiety (difficulty coping)
- ❑ Hearing loss: right, left, both
- ❑ Syncope (fainting spells)
- ❑ Facial swelling. Where? _____
- ❑ Burning or swollen tongue
- ❑ Recent change in lifestyle or in your work
- ❑ Irritable, nervous, or uptight
- ❑ Dysphasia (difficulty enunciating)
- ❑ Dysopsia (visual problems other than eyeglasses)
- ❑ Dysmnesia (forgetful)
- ❑ Nausea
- ❑ Stress, Please explain _____
- ❑ Menstrual cycle problems pain, headaches, depression

**Do you do any of the following?**

- ❑ Chew gum
- ❑ Chew tobacco
- ❑ Bite nails
- ❑ Chew fingers
- ❑ Smoke (Please circle: cigarettes, pipe)
- ❑ Sleep on your (Please circle: stomach, side, back)
- ❑ Phone cradling
- ❑ T.V. watching with chin on hand
- ❑ Writing or keyboarding for work
- ❑ Heavy lifting at work
- ❑ Carry a heavy bag for work
- ❑ Abnormal sleeping position

Signature _____

Identify the location of your pain by making a circle on the drawings in the appropriate areas. Use an X to mark the areas that hurt most severely or frequently. Next to the X write the word that best describes the type of pain: burning? Throbbing? Aching?

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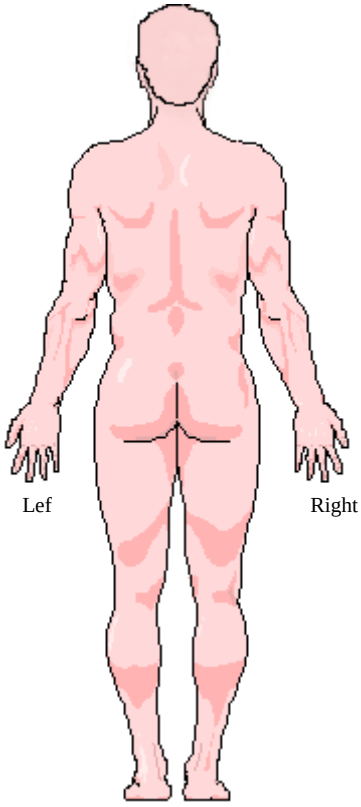


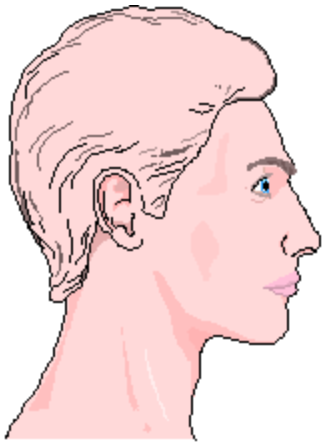

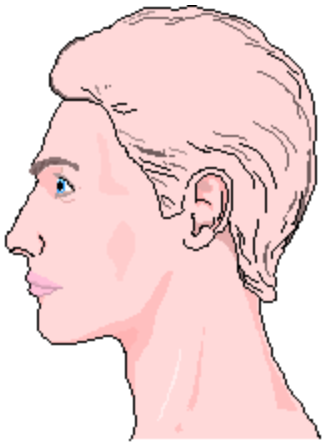

Mark areas 1-5 for degree of pain.
1= Minor discomfort, 5 = Unbearable pain

**I have read all 4 pages of the Pre-Treatment Questionnaire and have answered the questions as accurately as possible.**

**Name / Guardian _____ Date _____**