

## Head, Neck, & Jaw Joint Questionnaire

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

What do you feel is your major problem? (headaches, pain, jaw function, chewing, etc.)

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Y\_\_\_ N\_\_\_ Do you clench or clamp your teeth while you are sleeping?  
Y\_\_\_ N\_\_\_ Has anyone ever told you that they have heard you grind your teeth while you are sleeping?

Y\_\_\_ N\_\_\_ Must you chew on one side exclusively?

Y\_\_\_ N\_\_\_ Do you have any symptoms upon waking in the morning such as:

Y\_\_\_ N\_\_\_ Stiff jaw?                      Y\_\_\_ N\_\_\_ Sore jaw?                      Y\_\_\_ N\_\_\_

Headaches?

Y\_\_\_ N\_\_\_ Sore teeth?                      Y\_\_\_ N\_\_\_ Cracking or locking of

jaw joint?

Y\_\_\_ N\_\_\_ Does your jaw feel tired after a big meal?

Y\_\_\_ N\_\_\_ Does your jaw get locked open?

Y\_\_\_ N\_\_\_ Does your jaw get locked closed?

Y\_\_\_ N\_\_\_ Does it hurt when you chew?

Y\_\_\_ N\_\_\_ Does it hurt when you open wide to take a big bite?

Y\_\_\_ N\_\_\_ Do you have pain in your ears while eating?

Y\_\_\_ N\_\_\_ Do you have pain in the front of your ears while eating?

Y\_\_\_ N\_\_\_ Do you have pain in your:

Y\_\_\_ N\_\_\_ Shoulder?                      Y\_\_\_ N\_\_\_ Eyes?

Y\_\_\_ N\_\_\_ Neck?                              Y\_\_\_ N\_\_\_ Back?

Y\_\_\_ N\_\_\_ Throat?                              Y\_\_\_ N\_\_\_ Jaw?

Y\_\_\_ N\_\_\_ Face?                              Y\_\_\_ N\_\_\_ Temples?

Y\_\_\_ N\_\_\_ Do you often suffer from headaches? Describe them and how often you have them:

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Y\_\_\_ N\_\_\_ Does pain or discomfort disturb your sleep? How often:

Y\_\_\_ N\_\_\_ Does pain or discomfort interfere with your daily routine or other activities?

Y\_\_\_ N\_\_\_ Have you ever had whiplash? When? \_\_\_\_\_

Y\_\_\_ N\_\_\_ Have you ever had a severe head injury? When?

Y\_\_\_ N\_\_\_ Have you ever had a severe jaw injury? When?

Y\_\_\_ N\_\_\_ Do you have a "nervous stomach"?

Y\_\_\_ N\_\_\_ Do you consider yourself to be under more stress than most people?

Y\_\_\_ N\_\_\_ Do you take tablets for nervousness, depression, or to help you relax?

Y\_\_\_ N\_\_\_ Do you take medication for pain?

Y \_\_\_ N \_\_\_ Have you ever been treated for jaw joint pain or discomfort?  
Please list date, place, and names of doctors who treated you for this.

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Please comment on any medical history or dental history that you feel may be important in the diagnosis and treatment of your condition. Please use reverse side of this form if you need additional space.

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Patient's Signature: \_\_\_\_\_