

## Questionnaire before your orofacial pain & TMJ consultation

Please fill in this questionnaire before your consultation and bring it with you. It helps us understand your pain and make the best use of the consultation time. Tick everything that applies; if you don't know an answer, you can leave it blank. Your information is confidential.

### 1 Personal details

Full name \_\_\_\_\_

Date of birth \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Date \_\_\_\_\_

#### Who suggested you come?

☐ My dentist ☐ My GP ☐ Neurologist ☐ ENT doctor ☐ Another doctor ☐ My own decision

### 2 Reason for the consultation

Briefly describe the main problem, in your own words:

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### 3 Where does it hurt? (tick the side)

|                                 | Left                     | Right                    |
|---------------------------------|--------------------------|--------------------------|
| Jaw joint (in front of the ear) | <input type="checkbox"/> | <input type="checkbox"/> |
| Cheek / chewing muscles         | <input type="checkbox"/> | <input type="checkbox"/> |
| Temple                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Teeth / gums                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Tongue, lips, inside the mouth  | <input type="checkbox"/> | <input type="checkbox"/> |
| Around the eye                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Back of the head / neck         | <input type="checkbox"/> | <input type="checkbox"/> |
| The whole face or head          | <input type="checkbox"/> | <input type="checkbox"/> |

### 4 Onset and course

When did the pain start? (approx.) \_\_\_\_\_ How many days in the last month? \_\_\_\_\_

#### How did it start?

☐ Suddenly ☐ Gradually ☐ After dental treatment or dental work ☐ After an extraction ☐ After an injury / accident  
☐ During a stressful period ☐ No obvious cause

#### How often?

☐ All the time ☐ Daily, with breaks ☐ A few times a week ☐ Rarely, in episodes

#### When is it worst?

☐ In the morning, on waking ☐ During the day ☐ In the evening ☐ It wakes me up ☐ No particular time

### 5 Pain intensity

Right now 

|   |   |   |   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|

 0 = none · 10 = worst imaginable

On average, in the last month 

|   |   |   |   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|

At its worst, in the last month 

|   |   |   |   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|

### 6 What is the pain like?

☐ Dull, pressing ☐ Throbbing ☐ Burning ☐ Stabbing, like an electric shock ☐ Tight, tired muscles

☐ Other: \_\_\_\_\_

## 7 What triggers or worsens it? What relieves it?

### Worse with:

- ☐ Chewing ☐ Opening wide, yawning ☐ Talking ☐ Touching the face (washing, shaving, make-up)  
☐ Cold, draughts ☐ Stress ☐ Physical effort ☐ Other: \_\_\_\_\_

### Better with:

- ☐ Rest ☐ Heat ☐ Cold ☐ Massage ☐ Medication ☐ Nothing

## 8 Jaw and joint

- ☐ Joint noises (click, pop) ☐ Grating, crunching ☐ My jaw locks and won't open wide ☐ My jaw locks open  
☐ Opening my mouth is limited or painful ☐ My bite has changed recently

## 9 Habits (bruxism)

- ☐ I've been told I grind my teeth in my sleep ☐ I wake up with tired or sore jaws ☐ I clench my teeth during the day  
☐ I bite my nails, cheeks, pens ☐ I chew gum a lot ☐ My teeth are worn or my dental work cracked

## 10 Sleep

- ☐ I snore ☐ Pauses in my breathing have been noticed ☐ I'm sleepy during the day ☐ I sleep badly or wake up tired  
☐ I have been diagnosed with sleep apnoea

## 11 Headaches and other pain

Headaches: how many days a month? \_\_\_\_\_ Diagnosed with migraine? Yes / No \_\_\_\_\_

- ☐ Neck, shoulder pain ☐ Back pain ☐ Pain in many parts of the body ☐ Tinnitus (ringing in the ears) ☐ Dizziness

## 12 What have you tried so far for this pain?

|                                                                | Helped                   | Didn't help              |
|----------------------------------------------------------------|--------------------------|--------------------------|
| Splint (night guard)                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercises, physiotherapy, massage                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Painkillers or other medication                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Injections                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental treatment (extractions, root canals, grinding of teeth) | <input type="checkbox"/> | <input type="checkbox"/> |
| Other                                                          | <input type="checkbox"/> | <input type="checkbox"/> |

Details (which medication, when, who recommended it) \_\_\_\_\_

## 13 General health

- ☐ Heart disease / blood pressure ☐ Diabetes ☐ Thyroid ☐ Neurological conditions ☐ Arthritis, rheumatic disease  
☐ Fibromyalgia ☐ Depression, anxiety ☐ Pregnancy

Other conditions \_\_\_\_\_

Medication you take now \_\_\_\_\_

Allergies \_\_\_\_\_

Surgery or injuries to the head, face, neck \_\_\_\_\_

## 14 How much does the pain affect you? (last month)

|                        |   |   |   |   |   |   |   |   |   |   |    |                                  |
|------------------------|---|---|---|---|---|---|---|---|---|---|----|----------------------------------|
| Eating                 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 = not at all · 10 = completely |
| Sleep                  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |                                  |
| Work, daily activities | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |                                  |
| Mood                   | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |                                  |

## 15 What do you expect from the consultation?

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This questionnaire does not replace a medical consultation. At the consultation, the doctor may also ask you to fill in standardised questionnaires used internationally for orofacial pain and TMJ disorders.