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Head and Facial Pain Questionnaire

Date _____ Name_____

Your response to these questions greatly assists us in helping to make the proper diagnosis.

Did someone refer you here? Yes _____ No _____ Name _____

I. Check all the symptoms that apply to you.

Head aches _____	Face Pain _____
Neck Pain _____	Eye pain or burn _____
Jaw Pain _____	Hearing problems _____
Ear Pain _____	Dizziness _____
Pain in front of Ear _____	Teeth sore or sensitive _____

II. Approximately how long has this problem occurred? 1 month ____ 3 months _____
6 months _____ Over 6 months_____ Over 1 year _____ Over 5 years _____

III. Is this pain: constant____ aching ____ burning ____ stabbing____
worse in the afternoon ____ worse in the morning ____ when chewing_____
when opening wide _____ when touching your teeth_____

Is your pain worsened by _____ coughing _____ sneezing _____laying down

IV. Does your jaw: click or pop ____ catch or "hang-up" ____ lock closed _____
lock open _____ make a grinding noise _____
If this is not occurring now, have these things occurred in the past? Yes___ No___
Comments: _____
_____

V. Can you remember any accident in which you hit or injured your jaw? Yes ___ No___
Comments: _____

Please use the reverse side
for additional comments.