GARY L. DENNINGTON DDS PC
Fellow of the American Academy of Craniofacial Pain
Diplomate of the American Board of Craniofacial Pain

DATE: ____/____/_____ OFFICE USE Patient ID:_____ Chart ID_____
First Name_____ Middle Initial_____ Last Name_____
Other Dentists if applicable _____ Other Physician Name_____
Whom may we thank for referring you to our practice? _____

Responsible Party *(If someone other than patient)*
First Name _____ Middle Initial_____ Last Name_____
Street Address _____
City _____ State _____ Zip_____
Home Phone _____ Work Phone _____ Cell Phone _____
Birth Date ____/____/_____ Social Security Number_____-_____-_____ Driver License _____

Patient Information
Street Address _____
City _____ State _____ Zip_____
Home Phone _____ Work Phone _____ Cell Phone _____
_____Male _____Female _____Married _____Single _____Divorced _____Separated _____Widowed
Birth Date ____/____/_____ Social Security Number_____-_____-_____ Driver License _____
Email _____ Spouse Name _____
Occupation_____ Employer Name _____
Employment Status ___Full Time ___Part Time ___Retired Height _____Feet _____Inches
Student Status ___Full Time ___Part Time Weight_____
Medicaid ID _____ Preferred Dentist _____
Employer ID _____ Preferred Pharmacy _____
Carrier ID _____ Preferred Hygienist _____

Insurance Information

Primary Insurance Information
First Name of Insured_____ Middle Initial_____ Last Name_____
Policy/Group No. _____ Relationship to Insured _____Self _____Spouse _____Child _____Other
Insurance ID No. _____ Insured Birth Date ____/____/_____ Insured Soc Sec No. _____
Employer _____ Ins. Company _____
Insured Address if different than patient's
Street Address _____
City, State, Zip _____
Street Address _____
City, State, Zip _____
Telephone _____

Secondary Insurance Information
First Name of Insured_____ Middle Initial_____ Last Name_____
Policy/Group No. _____ Relationship to Insured _____Self _____Spouse _____Child _____Other
Insurance ID No. _____ Insured Birth Date ____/____/_____ Insured Soc Sec No. _____
Employer _____ Ins. Company _____
Insured Address if different than patient's
Street Address _____
City, State, Zip _____
Street Address _____
City, State, Zip _____
Telephone _____

Patient Signature _____ Date _____

Medical History Questionnaire

DATE: ____/____/_____ OFFICE USE Patient ID:_____

NAME _____ DATE OF BIRTH ___/___/_____ MALE _____ FEMALE _____

This questionnaire was designed to provide important facts regarding the history of your pain or condition. the information you provide will assist in reaching diagnosis and determining the source of your problem. Please take your time and answer each questions as completely and honestly as possible. Please sign each page.

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

___ Yes ___No Antibiotics	___ Yes ___No Latex	___ Yes ___No Sedatives
___ Yes ___No Aspirin	___ Yes ___No Local Anesthetics	___ Yes ___No Sleeping pills
___ Yes ___No Barbiturates	___ Yes ___No Metals	___ Yes ___No Sulfa drugs
___ Yes ___No Codeine	___ Yes ___No Penicillin	___ Other _____
___ Yes ___No Iodine	___ Yes ___No Plastic	___ Other _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Medication name	Dosage/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY: (Please indicate dates on items marked current or past) (N=Never / C=Current / P=Past)

Medical Condition	N	C	P	Date	Medical Condition	N	C	P	Date
Periodontal *(gum disease)*	_	_	_	_____	Hemophilia	_	_	_	_____
Oral surgery	_	_	_	_____	Hepatitis	_	_	_	_____
Wisdom teeth removed	_	_	_	_____	Hormone problems	_	_	_	_____
Other teeth removed	_	_	_	_____	Hypertension	_	_	_	_____
Grind or clench teeth	_	_	_	_____	Hypoglycemia	_	_	_	_____
Bite adjusted by dentist	_	_	_	_____	Immune system disorder	_	_	_	_____
Chew gum regularly	_	_	_	_____	Infectious mononucleosis	_	_	_	_____
Orthodontic treatment	_	_	_	_____	Injury to face	_	_	_	_____
Teeth removed for ortho	_	_	_	_____	Injury to mouth	_	_	_	_____
Bite or chew fingernails	_	_	_	_____	Injury to neck	_	_	_	_____
Badly worn teeth	_	_	_	_____	Injury to teeth	_	_	_	_____
Loose teeth	_	_	_	_____	Insomnia	_	_	_	_____
Accident to teeth	_	_	_	_____	Jaw joint surgery	_	_	_	_____
Splint, retainer	_	_	_	_____	Kidney problems	_	_	_	_____
or night guard					Low energy	_	_	_	_____
Allergies	_	_	_	_____	Lung disease	_	_	_	_____
Acid reflux	_	_	_	_____	Meniere's disease	_	_	_	_____
Arteriosclerosis	_	_	_	_____	*(inner ear disease)*				
Arthritis	_	_	_	_____	Menopausal problems	_	_	_	_____
Asthma	_	_	_	_____	Multiple sclerosis	_	_	_	_____
Backaches	_	_	_	_____	Muscle aches	_	_	_	_____
Blood pressure - High	_	_	_	_____	Muscle shaking *(tremors)*	_	_	_	_____
Blood pressure - Low	_	_	_	_____	Muscle spasms or cramps	_	_	_	_____

Patient Signature _____ Date _____

Medical Condition	N	C	P	Date
Cancer	_	_	_	_____
Chronic fatigue	_	_	_	_____
Chronic pain	_	_	_	_____
Cold hands and feet	_	_	_	_____
Cold sores	_	_	_	_____
Depression	_	_	_	_____
Diabetes	_	_	_	_____
Difficulty concentrating	_	_	_	_____
Difficulty sleeping	_	_	_	_____
Dizziness	_	_	_	_____
Epilepsy	_	_	_	_____
Fainting spells	_	_	_	_____
Fatigue easily	_	_	_	_____
Fibromyalgia	_	_	_	_____
Frequent stressful situations	_	_	_	_____
Frequent urination	_	_	_	_____
Gall bladder problems	_	_	_	_____
General anesthesia	_	_	_	_____
Glaucoma	_	_	_	_____
Hearing impaired	_	_	_	_____
Heart attack	_	_	_	_____
Heartburn	_	_	_	_____
Heart disease	_	_	_	_____
Heart murmur	_	_	_	_____
Heart pacemaker	_	_	_	_____
Heart palpitations	_	_	_	_____
Heart problems	_	_	_	_____

Medical Condition	N	C	P	Date
Muscular dystrophy	_	_	_	_____
Nasal allergies	_	_	_	_____
Needing extra pillows to help breathing at night	_	_	_	_____
Neuralgia	_	_	_	_____
Numbness of fingers	_	_	_	_____
Osteoarthritis	_	_	_	_____
Osteoporosis	_	_	_	_____
Pacemaker	_	_	_	_____
Prior Orthodontic treatment	_	_	_	_____
Psychiatric care	_	_	_	_____
Rheumatic fever	_	_	_	_____
Rheumatoid arthritis	_	_	_	_____
Scoliosis	_	_	_	_____
Sinus problems	_	_	_	_____
Sleep apnea	_	_	_	_____
Speech difficulties	_	_	_	_____
Stroke	_	_	_	_____
Swallowing problems	_	_	_	_____
Swollen, stiff or painful joints	_	_	_	_____
Tendency for ear infections	_	_	_	_____
Tendency for sore throats	_	_	_	_____
Thyroid disorder	_	_	_	_____
Tired muscles	_	_	_	_____
Tonsils removed	_	_	_	_____
Tuberculosis	_	_	_	_____
Urinary disorders	_	_	_	_____

	C	P	Date
Other _____	_	_	_____
Other _____	_	_	_____
Other _____	_	_	_____

	C	P	Date
Other _____	_	_	_____
Other _____	_	_	_____
Other _____	_	_	_____

ADDITIONAL MEDICAL HISTORY ITEMS:

Medical Condition	N	C	P	Date
Recreational drugs	_	_	_	_____

Medical Condition	N	C	P	Date
HIV/AIDS	_	_	_	_____

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

___ Yes ___No Appendectomy
___ Yes ___No Back
___ Yes ___No Ear
___ Yes ___No Gallbladder
___ Yes ___No Heart
___ Yes ___No Hernia repair
___ Other _____

___ Yes ___No Hysterectomy
___ Yes ___No Lung
___ Yes ___No Nasal
___ Yes ___No Thyroid
___ Yes ___No Tonsillectomy
___ Yes ___No Tubal
___ Other _____

___ Yes ___No Uvulectomy
___ Yes ___No Periodontal
Other _____

Patient Signature _____ Date _____

SOCIAL HISTORY:

Tobacco Use: Cigarettes ___ Never smoked ___ Current Smoker # of packs per day___ # of years___
___ Quit When did you quit? _____

Other tobacco: ___ Pipe ___ Cigar ___ Snuff ___ Chew

Alcohol Use: Do you drink alcohol? ___ Yes ___ No If yes, # of drinks per week___

Caffeine Intake: ___ None ___ Coffee/Tea/Soda # of cups per day___

Additional: ___ Yes ___No Regular exercise

PATIENT SIGNATURE

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.
Patient Signature _____ Date _____

I certify that the medical history information is complete and accurate.
Patient Signature _____ Date _____

Head, Neck and Facial Pain Questionnaire

DATE: ____/____/_____ OFFICE USE Patient ID:_____

NAME _____ DATE OF BIRTH ___/___/_____ MALE _____ FEMALE _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please number your complaints with #1 being the most severe, #2 the next most severe, etc.

#1 = the most severe symptom

TMD/PAIN COMPLAINTS

___ Difficulty swallowing
___ Dizziness
___ Facial pain
___ Headaches
___ Jaw clicking
___ Jaw locking
___ Jaw pain
___ Limited mouth opening
___ Difficulty opening mouth
___ Difficulty closing mouth
___ Migraines
___ Morning head pain
___ Morning Hoarseness
___ Neck Pain
___ Shoulder pain
___ Nocturnal teeth grinding
___ Pain when chewing

___ Eye pain
___ Eye twitching
___ Sore facial muscles
___ Ear Pain
___ Fullness sinus
___ Ringing in the ears
___ Numbness - upper limbs

SLEEP BREATHING COMPLAINTS

___ CPAP intolerance
___ Difficulty falling asleep
___ Fatigue
___ Frequent heavy snoring
___ Frequent heavy snoring which affects the sleep of others
___ Gasping when waking up
___ Nighttime choking spells
___ Significant daytime drowsiness
___ Sleepy while driving
___ Witnessed apneic events

Other: Write In

___ _____ ___ _____
___ _____ ___ _____

Patient Signature _____ Date _____

SYMPTOMS

HEAD PAIN
Alternative Place for LOCATION on the PAIN Hx TAB

___ Yes ___No Entire head *(Generalized)*
[L] [R] [B] Front of your head *(Frontal)*
___ Yes ___No Top of the head
[L] [R] [B] Back of your head
[L] [R] [B] In your temples

JAW PAIN
[L] [R] [B] Jaw pain - on opening
[L] [R] [B] Jaw pain - while chewing
[L] [R] [B] Jaw pain - at rest

JAW SYMPTOMS
___ Yes ___No Jaw popping
[L] [R] [B] Jaw clicking
___ Yes ___No Jaw locks closed
___ Yes ___No Jaw locks opened
___ Yes ___No Teeth grinding

MOUTH AND NOSE RELATED CONDITION
___ Yes ___No Burning tongue
___ Yes ___No Frequent biting of cheek
___ Yes ___No Frequent snoring
___ Yes ___No Broken teeth
___ Yes ___No Teeth clenching
___ Yes ___No Dry mouth

EAR RELATED CONDITIONS
___ Yes ___No Buzzing in the ears
___ Yes ___No Tinnitus *(ringing in the ears)*
___ Yes ___No Ear pain
___ Yes ___No Ear congestion
___ Yes ___No Pain in front of the ear
___ Yes ___No Hearing loss
___ Yes ___No Recurrent ear infections
___ Yes ___No Pain behind the ear
___ Yes ___No Vertigo/Dizziness

EYE RELATED CONDITIONS
Double Vison, Photophobia in PAIN Hx

___ Yes ___No Blurred vision
___ Yes ___No Eye pain
___ Yes ___No Pain or pressure behind the eyes
___ Yes ___No Eyelid twitching

THROAT, NECK & BACK RELATED CONDITIONS CONTINUED
___ Yes ___No Back pain - lower
___ Yes ___No Back pain - middle
___ Yes ___No Back pain - upper
___ Yes ___No Chronic sore throat
___ Yes ___No Constant feeling of a foreign object in throat
___ Yes ___No Difficulty in swallowing
___ Yes ___No Limited movement of neck
___ Yes ___No Neck pain
___ Yes ___No Numbness in the hands or fingers
___ Yes ___No Sciatica
___ Yes ___No Scoliosis
___ Yes ___No Shoulder pain
___ Yes ___No Shoulder stiffness
___ Yes ___No Swelling in the neck
___ Yes ___No Swollen glands
___ Yes ___No Thyroid enlargement
___ Yes ___No Tightness in throat
___ Yes ___No Tingling in the hands or fingers
___ Yes ___No Chronic sinusitis

Other _____
Other _____
Other _____
Other _____

HISTORY OF SYMPTOMS

When did your condition first occur? _____ _____
What do you believe is the cause or condition of your pain or condition?_____
Pick one:

___a motor vehicle accident	___a motorcycle accident	___work related accident
___an athletic endeavor	___a fight	___playground incident
___accident	___illness	___injury
___unknown	___fall	___other _____ _____

If accident, enter date _____
Is there anything that makes your pain or discomfort worse?_____
Is there anything that makes your pain or discomfort better?_____
What other information is important to your pain or condition?_____

Patient Signature _____ Date _____

LIST ANY TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

Practitioner's Name	Specialty	Treatment	Approximate Date

HEAD PAIN HISTORY

Pain Qualities

LOCATION

Which side are the headaches worse?
(Choose one from below)
___right side
___both sides
___the left side
___the right side

Headache spreads to
(Choose one from below)
___ the temporal area down to neck
___ the temple
___ the back of the head
___ the temple
___the back of the head
___the forehead

SEVERITY ON A SCALE OF 0-10

0=No Pain 10=Worst Pain Imaginable
___Jaw Pain on a Numeric Pain Scale
___Headaches on a 0-10 Pain Scale
___Neck Pain on a Numeric Pain Scale
___Facial Pain on a 0-10 Pain Scale

FREQUENCY

___ Yes ___No Occasional
___ Yes ___No Frequent
___ Yes ___No Constant

DURATION

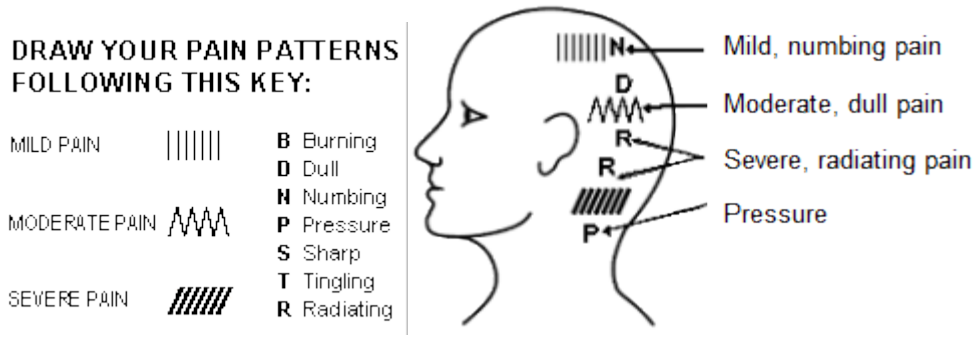
___ Yes ___No Seconds
___ Yes ___No Minutes
___ Yes ___No Hours
___ Yes ___No Days
___ Yes ___No Weeks

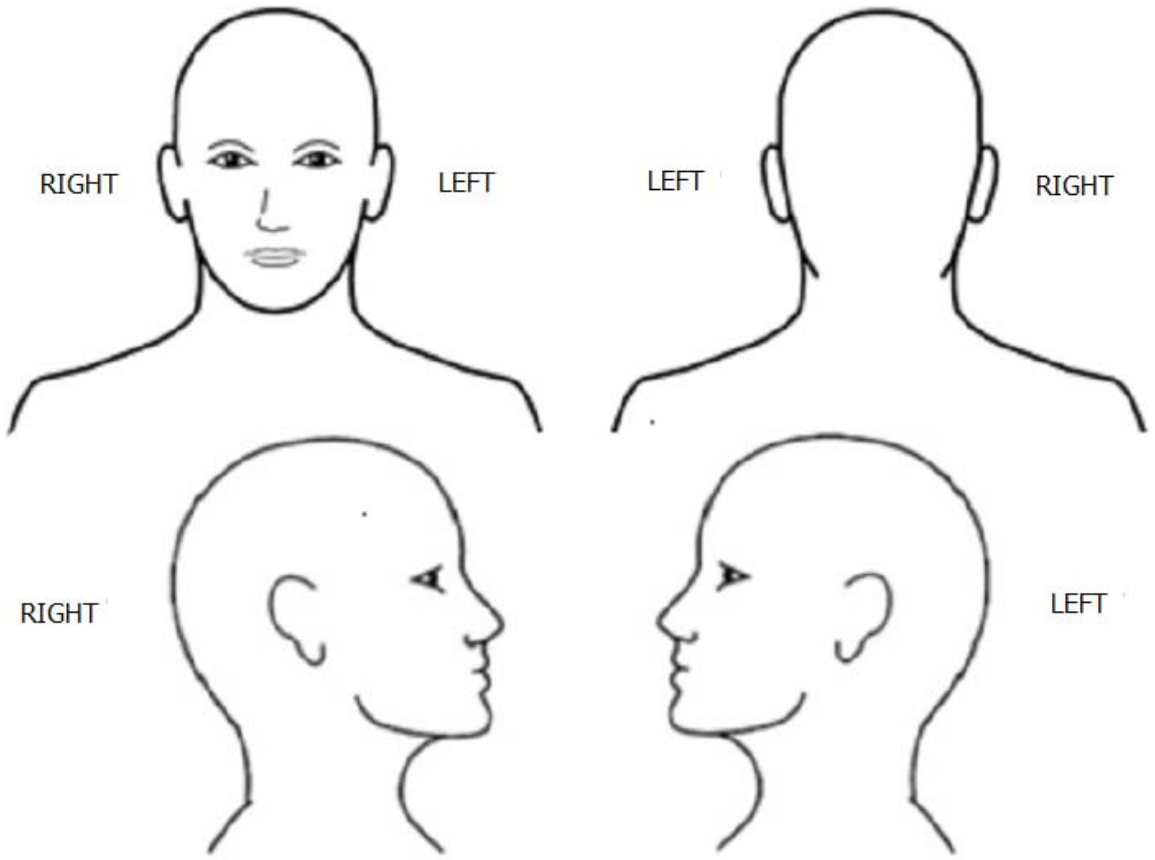
When having pain do you experience:

___ Yes ___No Dizziness
___ Yes ___No Double vision
___ Yes ___No Fatigue
___ Yes ___No Nausea
___ Yes ___No Sensitivity to light (*photophobia)*
___ Yes ___No Sensitivity to noise
___ Yes ___No Throbbing
___ Yes ___No Vomiting
___ Yes ___No Burning

Patient Signature _____ Date _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY





Enter any text to appear below the image _____

PATIENT SIGNATURE

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

I certify that the medical history information is complete and accurate.

Patient Signature _____ Date _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Check one in each row:	**0=No chance of dozing**	**1=Slight chance of dozing**	**2=Moderate chance of dozing**	**3=High chance of dozing**
Sitting and reading	_____	_____	_____	_____
Watching TV	_____	_____	_____	_____
Sitting inactive in a public place (i.e. a theater or a meeting)	_____	_____	_____	_____
As a passenger in a car for an hour without a break	_____	_____	_____	_____
Lying down to rest in the afternoon when circumstances permit	_____	_____	_____	_____
Sitting and talking to someone	_____	_____	_____	_____
Sitting quietly after a lunch without alcohol	_____	_____	_____	_____
In a car, while stopping for a few minutes in traffic	_____	_____	_____	_____

TOTAL SCORE: _____ (Add columns 0-3)

FATIGUE SCALE

During the past week:	**No<<**						**Yes>>**
	1	**2**	**3**	**4**	**5**	**6**	**7**
I felt fatigued and had less motivation	__	__	__	__	__	__	__
I felt fatigued and did not desire to exercise	__	__	__	__	__	__	__
I felt fatigued often	__	__	__	__	__	__	__
I felt fatigue that interfered with my physical functioning	__	__	__	__	__	__	__
I felt fatigued which caused me frequent problems	__	__	__	__	__	__	__
I felt fatigued which prevented sustained physical functioning	__	__	__	__	__	__	__
I felt fatigued and couldn't carry out certain duties and responsibilities	__	__	__	__	__	__	__
Fatigue was among my three most disabling symptoms	__	__	__	__	__	__	__
Fatigue interfered with my work, family or social life	__	__	__	__	__	__	__

TOTAL SCORE: _____

Patient Signature _____ Date _____

TMJ SCALE

This questionnaire is designed to help your doctor evaluate your problem. Please answer all questions as honestly as possible. use a **dark #2 lead pencil**. Mark answers clearly, erasing completely any changes. Make no marks outside answer spaces**. Do not skip any questions**, even if you are not absolutely sure.

Initials:_____ File No. (filled in by clinician) _____ _____ _____ _____ _____ _____

Today's Date ____/____/____ Age _____ Sex (mark one) [1] Male [2] Female

Marital Status (mark one) [1] Single [2] Married [3] Separated [4] Divorced [5] Widowed [6] Remarried

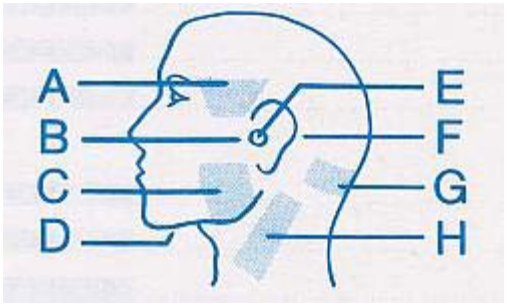
Ethnic/Racial Group (mark one) [1] Black [2] Hispanic [3] Oriental [4] White [5] Other

Number of School Years (mark one) [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] [11] [12] [13] [14] [15] [16] [17] [18] [19] [20+]

Problem Length [1] None [2] Less than 1 month [3] 1-5 Months [4] 6-11 Months [5] 1-2 Years [6] 3-5 Years [7] 6-10 Years [8] 10+ Years

1. This question should only be answered if you have upper and lower front teeth or are wearing a replacement for them. Open your mouth as wide as possible and position your hand as shown in the diagram at right. Place as many fingers as possible between your upper and lower front teeth. Now **mark one number** indicating the **number of fingers.**

	(mark one)
less than 1 finger	[0]
at least 1 finger	[1]
at least 2 fingers	[2]
at least 3 fingers	[3]
at least 4 fingers	[4]



For questions #2-8 below, locate each area on your face (except F) using the lettered diagram. Press each area firmly on both sides of you face. **Mark the number** that indicates the **maximum amount of pain** you feel using the following scale:

0 = **no pain**
1 = **slight pain**
2 = **moderate pain**
3 = **quite a bit of pain**
4 = **extreme pain**.

		(mark one)				
2.	Pressing my temples (A on diagram)	[0]	[1]	[2]	[3]	[4]
3.	Pressing my jaw joints (B on diagram)	[0]	[1]	[2]	[3]	[4]
4.	Pressing my jaw muscles (C on diagram)	[0]	[1]	[2]	[3]	[4]
5.	Pressing the muscles under the side of my jaw (D on diagram)	[0]	[1]	[2]	[3]	[4]
6.	Pressing in my ears (E on diagram)	[0]	[1]	[2]	[3]	[4]
7.	Pressing the back of my neck (G on diagram)	[0]	[1]	[2]	[3]	[4]
8.	Pressing the side of my neck (H on diagram)	[0]	[1]	[2]	[3]	[4]

Patient Signature _____ Date _____

Mark the number which best describes **how much of the time** each statement to the left applies to you, using the following key:

0 = none of the time
1 = a little bit of the time
2 = a moderate amount of time
3 = quite a bit of time
4 = all of the time

9.	Just a light touch on my face causes shock-like pain.	[0]	[1]	[2]	[3]	[4]
10.	My jaw must click and pop before I can open it wide.	[0]	[1]	[2]	[3]	[4]
11.	My jaw opens all the way without any sideways movements	[0]	[1]	[2]	[3]	[4]
12.	My jaw locks open.	[0]	[1]	[2]	[3]	[4]
13.	I have headaches which begin after seeing flashes of light or dark spots.	[0]	[1]	[2]	[3]	[4]
14.	My jaw moves easily.	[0]	[1]	[2]	[3]	[4]
15.	I have health problems which haven't responded to treatment.	[0]	[1]	[2]	[3]	[4]
16.	I have pain in my jaw joint(s) (B on the diagram).	[0]	[1]	[2]	[3]	[4]
17.	My jaw tires easily when chewing.	[0]	[1]	[2]	[3]	[4]
18.	I have headaches which are made worse by bright light	[0]	[1]	[2]	[3]	[4]
19.	It hurts my teeth when I bite.	[0]	[1]	[2]	[3]	[4]
20.	I have muscle or joint pain in areas other than my head or neck.	[0]	[1]	[2]	[3]	[4]
21.	I can move my jaw more to one side than the other.	[0]	[1]	[2]	[3]	[4]
22.	I feel tense and worried.	[0]	[1]	[2]	[3]	[4]
23.	I have drainage from my ear(s).	[0]	[1]	[2]	[3]	[4]
24.	I feel sad and depressed.	[0]	[1]	[2]	[3]	[4]
25.	I clench my teeth.	[0]	[1]	[2]	[3]	[4]
26.	My bite feels comfortable.	[0]	[1]	[2]	[3]	[4]
27.	I have jaw pain which gets worse the more I move my jaw.	[0]	[1]	[2]	[3]	[4]
28.	It is difficult to find a comfortable position for my jaw.	[0]	[1]	[2]	[3]	[4]
29.	I have pain in my ear(s) (E on diagram).	[0]	[1]	[2]	[3]	[4]
30.	I have sinus problems.	[0]	[1]	[2]	[3]	[4]
31.	When I bite down normally, my front teeth touch.	[0]	[1]	[2]	[3]	[4]
32.	During my life, I've had many different painful disorders.	[0]	[1]	[2]	[3]	[4]
33.	I have facial pain which comes on suddenly like electric shocks.	[0]	[1]	[2]	[3]	[4]
34.	I can open my mouth as far as possible without pain.	[0]	[1]	[2]	[3]	[4]
35.	I have pain in or behind my eye(s).	[0]	[1]	[2]	[3]	[4]
36.	My jaw makes a grating or grinding noise when it opens and closes.	[0]	[1]	[2]	[3]	[4]
37.	I think my bite is off.	[0]	[1]	[2]	[3]	[4]
38.	I have pain which gets worse with stress or tension.	[0]	[1]	[2]	[3]	[4]
39.	My jaw clicks or pops when I chew.	[0]	[1]	[2]	[3]	[4]
40.	I can bite down hard without pain in my jaw.	[0]	[1]	[2]	[3]	[4]
41.	One painful problem is followed by another.	[0]	[1]	[2]	[3]	[4]
42.	I have jaw pain which makes me feel sick and feverish.	[0]	[1]	[2]	[3]	[4]
43.	I grind my teeth during the day.	[0]	[1]	[2]	[3]	[4]
44.	I have numb areas on my face.	[0]	[1]	[2]	[3]	[4]
45.	I use nerve pills, sleeping pills, or alcohol for relief.	[0]	[1]	[2]	[3]	[4]
46.	I can move my jaw smoothly.	[0]	[1]	[2]	[3]	[4]
47.	I can chew without bumping my teeth unexpectedly.	[0]	[1]	[2]	[3]	[4]
48.	I have a feeling of pins and needles on my face.	[0]	[1]	[2]	[3]	[4]

Patient Signature _____ Date _____

Mark the number which best describes **how much of the time** each statement to the left applies to you, using the following key:

0 = none of the time
1 = a little bit of the time
2 = a moderate amount of time
3 = quite a bit of time
4 = all of the time

49.	I have pain in my jaw muscles (C on diagram).	[0]	[1]	[2]	[3]	[4]
50.	I have pain in the back of my neck (G on diagram).	[0]	[1]	[2]	[3]	[4]
51.	Over the years, I've been under a lot of stress.	[0]	[1]	[2]	[3]	[4]
52.	My jaw twitches or jerks uncontrollably.	[0]	[1]	[2]	[3]	[4]
53.	When I bite down normally, my back teeth touch.	[0]	[1]	[2]	[3]	[4]
54.	The way my front teeth fit seems to be changing.	[0]	[1]	[2]	[3]	[4]
55.	A light touch on one side of my face causes shock-like pain on the other.	[0]	[1]	[2]	[3]	[4]
56.	I have a ringing in my ear(s).	[0]	[1]	[2]	[3]	[4]
57.	I have pain which gets worse with certain people or situations.	[0]	[1]	[2]	[3]	[4]
58.	I have pain in the side(s) of my neck (H on diagram).	[0]	[1]	[2]	[3]	[4]
59.	I have a steady pain across my forehead.	[0]	[1]	[2]	[3]	[4]
60.	I have many changing pains.	[0]	[1]	[2]	[3]	[4]
61.	I feel angry.	[0]	[1]	[2]	[3]	[4]
62.	Other people notice noise from my jaw when I chew.	[0]	[1]	[2]	[3]	[4]
63.	I can chew food as well as I used to.	[0]	[1]	[2]	[3]	[4]
64.	I have health problems which seem to be getting worse.	[0]	[1]	[2]	[3]	[4]
65.	I have pain in the muscles under my jaw (D on diagram).	[0]	[1]	[2]	[3]	[4]
66.	I have pain in my temple(s) (A on diagram).	[0]	[1]	[2]	[3]	[4]
67.	I feel anxious.	[0]	[1]	[2]	[3]	[4]
68.	I can open my mouth as wide as I used to.	[0]	[1]	[2]	[3]	[4]
69.	The way my back teeth fit seems to be changing.	[0]	[1]	[2]	[3]	[4]
70.	I sleep well.	[0]	[1]	[2]	[3]	[4]
71.	I have head or facial pain which gets worse when I bend over.	[0]	[1]	[2]	[3]	[4]
72.	When I touch one side of my face, the other side gets numb.	[0]	[1]	[2]	[3]	[4]
73.	My jaw gets stuck and won't open all the way.	[0]	[1]	[2]	[3]	[4]
74.	The only real problems in my life are problems with my physical health.	[0]	[1]	[2]	[3]	[4]
75.	I've had conflicting doctors' opinions about health problems.	[0]	[1]	[2]	[3]	[4]
76.	I can move my jaw in any direction without pain.	[0]	[1]	[2]	[3]	[4]
77.	I have facial pain which gets worse in cold weather.	[0]	[1]	[2]	[3]	[4]
78.	I feel frustrated.	[0]	[1]	[2]	[3]	[4]
79.	I have a stuffy nose.	[0]	[1]	[2]	[3]	[4]
80.	Recently I've been under a lot of stress.	[0]	[1]	[2]	[3]	[4]
81.	I have headaches which make me feel sick to my stomach.	[0]	[1]	[2]	[3]	[4]
82.	I can take big bites of things like apples.	[0]	[1]	[2]	[3]	[4]
83.	I have work or family pressures.	[0]	[1]	[2]	[3]	[4]
84.	I have pain and stiffness in my finger joints.	[0]	[1]	[2]	[3]	[4]
85.	My back teeth feel like they fit properly.	[0]	[1]	[2]	[3]	[4]
86.	I believe I have an incurable problem in spite of reassurance by doctors.	[0]	[1]	[2]	[3]	[4]
87.	In the morning my teeth are sore and my jaw is tired.	[0]	[1]	[2]	[3]	[4]
88.	My ears feel blocked or stopped up.	[0]	[1]	[2]	[3]	[4]

Patient Signature _____ Date _____

Mark the number which best describes **how much of the time** each statement to the left applies to you, using the following key:

0 = none of the time
1 = a little bit of the time
2 = a moderate amount of time
3 = quite a bit of time
4 = all of the time

89.	I have many health problems.	[0]	[1]	[2]	[3]	[4]
90.	My jaw moves just as far forward as it used to.	[0]	[1]	[2]	[3]	[4]
91.	I have difficulty swallowing.	[0]	[1]	[2]	[3]	[4]
92.	I have pain behind my ear(s) (F on diagram).	[0]	[1]	[2]	[3]	[4]
93.	I have facial pain when other joints are also sore.	[0]	[1]	[2]	[3]	[4]
94.	I have nervous problems.	[0]	[1]	[2]	[3]	[4]
95.	I have throbbing headaches.	[0]	[1]	[2]	[3]	[4]
96.	I feel dizzy.	[0]	[1]	[2]	[3]	[4]
97.	I consider myself to be a sickly person.	[0]	[1]	[2]	[3]	[4]

Patient Signature _____ Date _____