word doc

HEAD, NECK, TMJ, AND FACIAL PAIN OR DYSFUNCTION SCREENING QUESTIONNAIRE

Name _____ Age _____ Sex _____ Date _____

1. One or more of the following symptoms may indicate a **TMJ** or **craniomandibular problem**. If you have any of the following symptoms, please mark the appropriate description.

HEAD/FACE
1. Forehead
2. Temporal
3. Tension headaches
4. Migraine headaches
5. Sinus headaches
6. Back of head headaches
7. Hair scalp tender to touch

NASAL
1. Sinus pain
2. Sinus problems
3. Post nasal drainage
4. Allergies

EAR
1. Ear pain without infection
2. Decreased hearing
3. Clogged, itchy, or stuffy
4. Ringing, buzzing
5. Dizziness
6. Balance problems

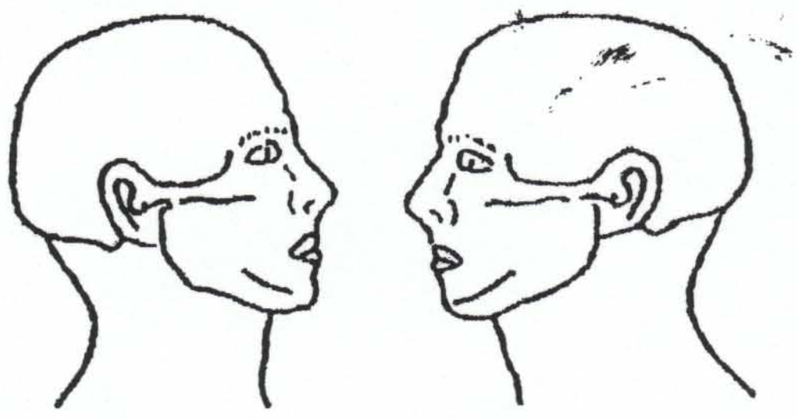
EYES
1. Pain in/around eyes
2. Bloodshot eyes
3. Sensitive to light
4. Tearing of eyes
5. Blurred vision
6. Pressure behind eye

THROAT
1. Swallowing difficulties
2. Feeling of foreign object in throat
3. Sore throat without infection
4. Voice changes
5. Laryngitis
6. Frequent coughing or clearing

NECK
1. Lack of mobility
2. Stiffness
3. Neck pain
4. Tired/sore neck muscles
5. Shoulder pain
6. Back pain: middle, lower
7. Arm/finger pain/numbness

JAW
1. Jaw pain
2. Jaw joint pain
3. Clicking/popping jaw joint
4. Grating sound in jaw joint
5. Pain in cheek muscles
6. Uncontrollable jaw movements
7. Jaw locks open/shut
8. Deviates to one side on opening or closing

MOUTH
1. Abnormal opening
2. Limited opening
3. Bad bite
4. Missing teeth
5. Excessive mouth breathing
6. Clench or grind teeth
7. Mouth discomfort
8. Inability to find "bite"

2. Please draw or mark any areas of particular pain or distress on the picture to the right.

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