PAIN EVALUATION

Please circle all that apply:

Chief Complaint(s): Jaw Pain Jaw Popping Lips Tongue Cheek Toothache Temple Neck Headaches Migraines Facial Pain Facial Swelling Bite Off Mouth Earache Limited Opening Tired Jaw Muscles Sore Jaw Muscles Jaw Locking Difficulty Opening
Other _____

Starting When? Less than 1 month 1-3 months 4-6 months 6 months – 1 year Over 1-year

After any of the following? Injury to Back Broken Jaw Broken Nose Head Surgery Neck Surgery Dental Filling Orthodontics Yawning Biting Head Injury Cervical Traction Dental Treatment Wide Opening Jaw Trauma Emotional Upset Neck Injury Whiplash Auto Accident Work Accident Not sure Nothing Other _____

When does it bother you? Morning Midday Evening Wakes you from sleep Intermittent Decreases during day Increases during day Not sure Other _____

How long does it last? _____

Describe the quality: Sharp Shooting Burning Numbness Ache Pulsing Throbbing Stabbing Electric Shock Other _____

Intensity Level (1 = lowest and 10 = highest) 1 2 3 4 5 6 7 8 9 10

What makes you feel worse? Yawning Chewing Swallowing Speaking Singing Shouting Brushing Teeth Turning Neck Turning Head Turning Trunk Moving Arms Moving Shoulders Stress Moving Jaw Nothing Don't Know Drinking Eating Touching Area Not Sure
Other _____

What makes you feel better? Rest Sleep Heat Ice Massage Medication Nothing
Other _____

Please describe if there is any method of positioning your jaw that will relieve your pain.

Have you had any serious trouble associated with any previous dental treatment?

Other Symptoms: None Eye Tearing Nasal Stuffiness Red Eyes Nausea Light Sensitivity Noise Sensitivity Swollen Eyes Droopy Eyes Ear Ringing Popping Noises Itchy Ears Hearing Loss Grating Noise Muscle Soreness Muscle Spasms Salivary Changes Eye Pressure Facial Swelling Cheek Biting Lip Biting Temperature Sensitivity Sensitive Teeth Tense Muscles Warm Muscles Tired Muscles Other _____

Past Treatment: None Physical Therapy Chiropractic Biofeedback Counseling Extraction Root Canal Crown/Bridge Dental Treatment Prosthetics Occlusal Adjustment Medication Nightguard Surgery Massage Orthodontics Other _____

Please indicate anything else about yourself which you suspect may be related to your visit.
