TMJ / HEADACHE QUESTIONNAIRE

Please complete this questionnaire to best of your ability. The more information we have, the more likely we will be able to get some answers.

DAYTIME SLEEPINESS SCALE
For the following situations, answer with one of the following numbers:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION	SCORE
Sitting and reading	
Watching television	
Sitting, inactive in a public place	
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 stopped for a few minutes in traffic	
	TOTAL SCORE

NIGHTTIME SLEEPINESS EVALUATION
Do you snore on most nights (>3 nights per week)?
☐ Yes ☐ No
Is your snoring loud? Can it be heard through a door or wall?
☐ Yes ☐ No
Has it ever been reported that you stop breathing or gasp during sleep?
☐ Never ☐ Occasionally ☐ Frequently
What is your collar size?
Male: ☐ Less than 17 inches ☐ More than 17 inches
Female: ☐ Less than 16 inches ☐ More than 16 inches

Do you occasionally fall asleep during the day when:
You are busy or active?
Yes ☐ No ☐
You are driving or stopped at a light?
Yes ☐ No ☐
Have you had or are you being treated for high blood pressure?
Yes ☐ No ☐

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

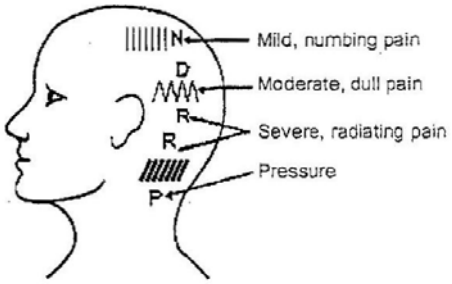
MILD PAIN

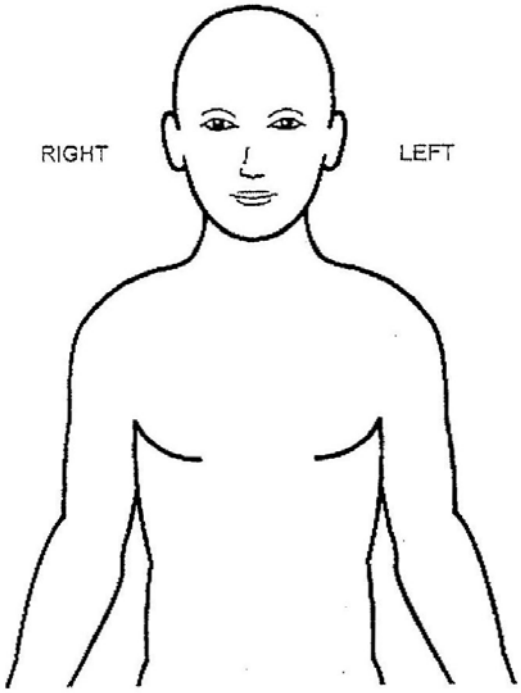
MODERATE PAIN

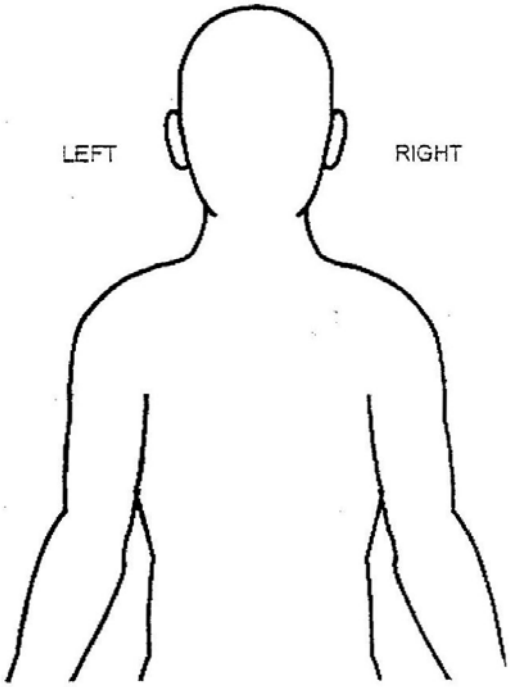
SEVERE PAIN

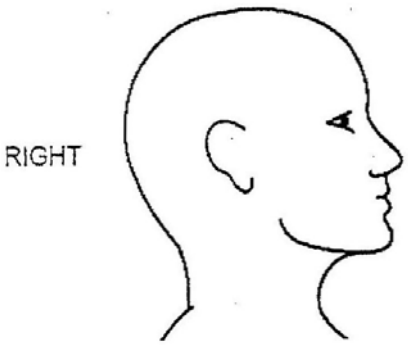
B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

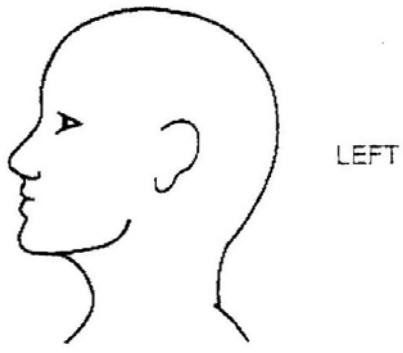
EXAMPLE











Patient Signature _____ Date _____

HISTORY OF SYMPTOMS

When did your condition first occur?

What do you believe is the cause of your pain or condition? (Check the box that applies)

- ☐ Motor vehicle accident
- ☐ Work-related incident
- ☐ Sporting injury/Playground injury
- ☐ Illness
- ☐ Fight
- ☐ Fall
- ☐ OTHER:

Have you missed any WORK as a result of the injury?
(please include length of time absent, and describe the task of employment that has become affected)

Have you been unable to carry out DAILY ACTIVITIES OF NORMAL LIFE as a result of the injury? (please describe the tasks of daily living that have become affected)

Has a doctor or dentist ever diagnosed a TMJ disorder prior to the accident/injury? (please explain)

Have you ever been involved in a PREVIOUS accident/injury? Please explain.

Medical attention previously sought.

PRACTIONER	TREATMENT & APPROXIMATE DATE
Medical doctor	
Neurologist	
Dentist	
Physiotherapist	
Chiropractor	
Massage Therapist	
OTHER:	

HISTORY OF ACCIDENT (complete this section ONLY if you were involved in an accident or traumatic incident)

Date of Accident: (month/day/year)

Were you… (check all that apply)

- ☐ A passenger in a vehicle?
- ☐ The driver of a vehicle?
- ☐ A pedestrian?
- ☐ At work?
- ☐ Did you fall?
- ☐ Were you hit by an object?
- ☐ OTHER:

If in a vehicle, where was the vehicle hit? (check all that apply)

- ☐ Front end
- ☐ Rear end
- ☐ Front right area
- ☐ Front left area
- ☐ Head-on
- ☐ Rear right area
- ☐ Rear left area
- ☐ Driver's side
- ☐ Passenger's side
- ☐ OTHER:

Indicate which body parts were painful shortly after the accident/incident? (check all that apply)

- ☐ Head
- ☐ Neck
- ☐ Face
- ☐ Jaw
- ☐ Left shoulder
- ☐ Right shoulder
- ☐ Left arm
- ☐ Right arm
- ☐ Lower back
- ☐ Upper back

Indicate if there was any DIRECT trauma to… (check all that apply)

- ☐ Forehead
- ☐ Face
- ☐ Chin
- ☐ Side of head
- ☐ Back of head
- ☐ Top of head
- ☐ Teeth
- ☐ Jaw
- ☐ OTHER:

Indicate the part of the vehicle that your body part (as checked above) struck forcibly…

- ☐ Steering wheel
- ☐ Windshield
- ☐ Driver's side window
- ☐ Passenger's side window
- ☐ Driver's side door
- ☐ Passenger's side door
- ☐ Headrest
- ☐ Seat
- ☐ Roof
- ☐ Interior of car
- ☐ OTHER: