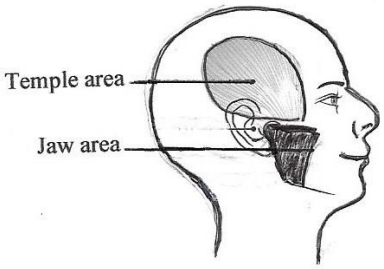
Initial Patient Questionnaire

Please answer the following questions. Your answers will help us learn how to **better help future patients** with jaw and temple pain**.**

Your responses will be confidential and will not be shared with your dentist.

1. In the **last 30 days**, where did you have any jaw or temple pain? **(Check all that apply)**

Left jaw area	☐ Yes ☐ No		Right jaw area	☐ Yes ☐ No
Left temple area	☐ Yes ☐ No		Right temple area	☐ Yes ☐ No



2. In the **last 30 days**, how long did any pain last in your jaw or temple area on either side?

☐ Pain comes and goes

☐ Pain is always present

3. In the **last 30 days**, have you had **pain or stiffness** in your **jaw** on awakening?

☐ Yes ☐ No

4. In the **last 30 days**, did the following activities **CHANGE** any pain (that is, make it better or make it worse) in your **jaw or temple** area on either side?

Chewing hard or tough food	☐ Yes	☐ No
Opening your mouth or moving your jaw forward or to the side	☐ Yes	☐ No
Jaw habits such as holding teeth together, clenching, grinding or chewing gum	☐ Yes	☐ No
Other jaw activities such as talking, kissing, or yawning	☐ Yes	☐ No

5. How would you rate your jaw or temple pain **RIGHT NOW**?

No Pain **Pain as bad as could be**

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6. In the **last 30 days**, how would you rate your **WORST** jaw or temple pain?

No Pain **Pain as bad as could be**

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7. In the **last 30 days**, **ON AVERAGE**, how would you rate your jaw or temple pain? That is, *your usual pain* at times you were in pain.

No Pain **Pain as bad as could be**

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. In the **last 30 days,** how many days have you had jaw or temple pain?

_____ day(s) (Every day = 30 days)

9. In the **last 30 days,** how many days did your jaw or temple pain keep you from doing your **USUAL ACTIVITIES** like work, school, or housework?

_____ day(s) (Every day = 30 days)

10. In the **last 30 days**, how much has jaw or temple pain **interfered** with your:

No Interference **Unable to carry on any activities**

	0	1	2	3	4	5	6	7	8	9	10
Daily activities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Recreational, social and family activities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to work	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

11. Is there a time in the day that your jaw or temple pain typically starts or is worse?

(Check one)

Upon awakening	☐ Yes	☐ No
In morning	☐ Yes	☐ No
In afternoon	☐ Yes	☐ No
In evening	☐ Yes	☐ No
No pattern	☐ Yes	☐ No

12. Did your jaw or temple pain **start with** or **get worse** from any of the following?

Trauma to jaw (fall, blow, sports, or vehicle/bike accidents)	☐ Yes	☐ No
Yawning or opening wide such as when eating	☐ Yes	☐ No
Eating hard, crunchy or chewy foods	☐ Yes	☐ No
Prolonged mouth opening or opening too wide during dental treatment	☐ Yes	☐ No
Too much pressure on your jaw during dental treatment	☐ Yes	☐ No
Wisdom tooth removal	☐ Yes	☐ No
Orthodontics (braces)	☐ Yes	☐ No
Jaw surgery to improve the way your teeth fit	☐ Yes	☐ No
Wearing a mouth guard to improve sleep and/or snoring	☐ Yes	☐ No
Oral habits such as holding teeth together, clenching/grinding teeth, or chewing gum	☐ Yes	☐ No
Stress or anxiety	☐ Yes	☐ No
Kissing	☐ Yes	☐ No
Intimate sexual behaviors	☐ Yes	☐ No
Other (describe):	☐ Yes	☐ No
I don't know	☐ Yes	☐ No

13. How long have you experienced jaw or temple pain? **(Check one)**

Less than 1 month	☐	6 months or more but less than 1 year	☐
1 month or more but less than 3 months	☐	1 year or more but less than 3 years	☐
3 months or more but less than 6 months	☐	3 years or more	☐

14. For each of the items below, please indicate the **level of limitation** during **the last 30 days**. If the activity has been completely avoided because it is too difficult, then fill in "10". If you avoid an activity for reasons other than pain or difficulty, then fill in the "not applicable" **(N/A).**

In the **LAST 30 days**:

		No Limitation										**Severe Limitation**
	N/A	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Chew tough food	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Chew chicken (e.g. prepared in oven)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Eat soft food requiring no chewing (e.g., mashed potatoes, apple sauce, pudding, pureed food)	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Open wide enough to drink from cup	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Swallow	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Yawn	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Talk	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Smile	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

15. In the **last 30 days,** have you had **headaches** in your temple area?

☐ Yes ------→ Go to question 16

☐ No headaches in temple area -----→ **SKIP** to question 18

16. In the **last 30 days,** how many **days** have you had **headaches** in your temple area?

_____ day(s) (Every day = 30 days)

17. In the **last 30 days**, did the following activities **CHANGE** your headaches in your temple area (that is, make it better or make it worse)?

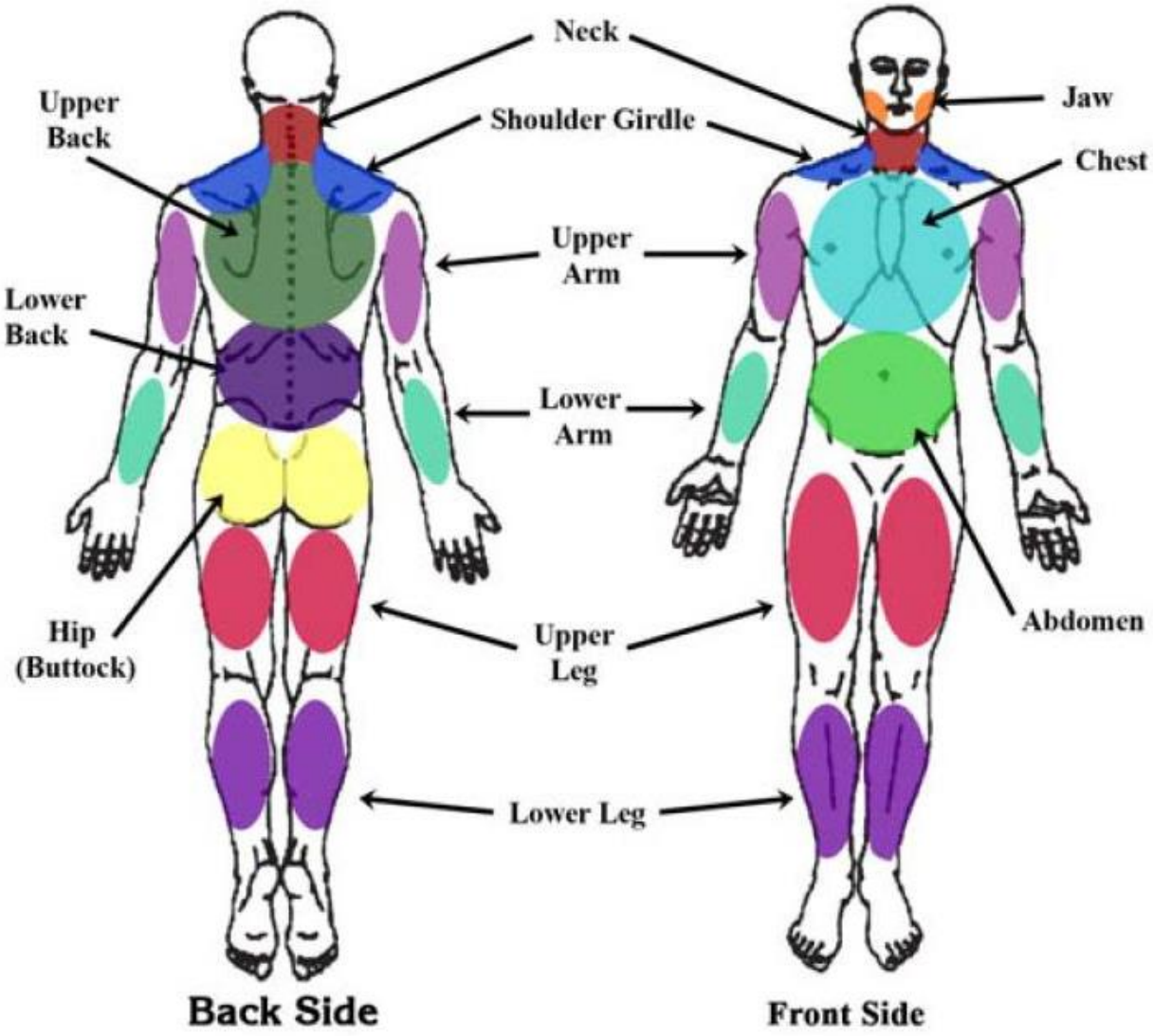
Chewing hard or tough food	☐ Yes ☐ No
Opening your mouth or moving your jaw forward or to the side	☐ Yes ☐ No
Jaw habits such as holding teeth together, clenching, grinding or chewing gum	☐ Yes ☐ No
Other jaw activities such as talking, kissing, or yawning	☐ Yes ☐ No

18. How often do you do each of the following activities, based on **the last 30 days?** (If the frequency of the activity varies, choose the higher option.)	**None of the time**	**A little or some of the time**	**Most or all of the time**
ACTIVITIES DURING SLEEP			
Clench or grind teeth when asleep	☐	☐	☐
Sleep in a position that puts pressure on the jaw (for example, on stomach, on the side)	☐	☐	☐
ACTIVITIES DURING WAKING HOURS			
Grind, clench or press teeth together during waking hours	☐	☐	☐
Hold, tighten, or tense muscles without clenching or bringing teeth together	☐	☐	☐
Hold or jut (thrust) jaw forward or to the side	☐	☐	☐
Place tongue forcibly against or between teeth	☐	☐	☐
Bite, chew or play with your tongue, cheeks, or lips	☐	☐	☐
Hold between the teeth or bite objects such as hair, pipe, pencil, pens, fingers, fingernails, etc.	☐	☐	☐
Use chewing gum	☐	☐	☐
Play musical instrument that involves use of mouth or jaw (for example, woodwinds, brass, string instruments)	☐	☐	☐
Lean with your hand on the jaw, such as cupping or resting the chin in the hand	☐	☐	☐
Chew food on one side only	☐	☐	☐
Sustained talking (for example, teaching, sales, customer service)	☐	☐	☐
Singing	☐	☐	☐
Hold telephone between your head and shoulders	☐	☐	☐

19. In the **last 30 days**, do you feel **refreshed or rested** when you awaken after a night's sleep?

None of the time	A little of the time	Some of the time	Most of the time	All of the time
☐	☐	☐	☐	☐

20. Please indicate below if you have had **pain or tenderness** over the **<u>past 7 days</u>** in each of the areas listed. Check all that apply.



Right Side

- ☐ Jaw
- ☐ Temple
- ☐ Shoulder
- ☐ Upper arm
- ☐ Lower arm
- ☐ Hip
- ☐ Upper leg
- ☐ Lower leg

Left Side

- ☐ Jaw
- ☐ Temple
- ☐ Shoulder
- ☐ Upper arm
- ☐ Lower arm
- ☐ Hip
- ☐ Upper leg
- ☐ Lower leg

Trunk

- ☐ Chest
- ☐ Abdomen
- ☐ Upper back
- ☐ Lower back

Neck

- ☐ Neck

No pain in any of these areas

- ☐

21. In general, have the areas you checked in question 20 been painful for **at least 3 months**?

☐ Yes ☐ No

22. Over the **last 2 weeks**, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

23. If you checked off **any** problems for question 22, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? **If you did NOT check any problems for question 22, SKIP to question 24.**

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

24. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

25. **In the past**, how many dentists or other health providers have you **ever** seen for your jaw or temple pain?

0	1	2	3	4	5	6	7	8	9	10	More than 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

The following questions ask **your opinion** about the treatment that your current dentist has just recommended for your **jaw or temple** pain.

26. How much do you think the treatment will **relieve** your pain?

No relief … **Complete relief**

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

27. How much do you think the treatment will i**mprove** your ability to use your jaw?

No improvement										**Complete improvement**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

28. How **satisfied** are you with the treatment that was presented?

Not at all satisfied										**Very satisfied**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

29. How **easy** will it be to follow the treatment?

Not at all easy										**Very easy**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

30. How **well** was the treatment **explained** to you?

Not at all well										**Very well**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Thank you for your time!