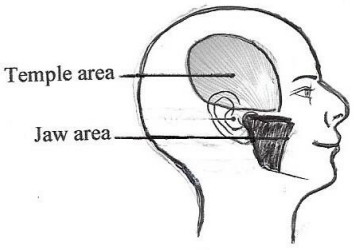
Patient Six-Month Follow-up Questionnaire

We want to know about your current pain, and ability to move and use your jaw. **Please answer the following questions.**

We would appreciate receiving your response within one week. Your compensation will be processed when the questionnaire is received. Your responses will be confidential and will not be shared with your dentist.

1. In the **last 30 days**, have you had any jaw or temple pain?



☐ Yes ----→ Go to question 2

☐ No ----→ **SKIP** to question 9

2. In the **last 30 days**, where have you had jaw or temple pain?

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

3. 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
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. 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
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. 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**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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

7. 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)

8. 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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

9. 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**:

	N/A		**No Limitation** 0	1	2	3	4	5	6	7	8	9	**Severe Limitation** 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	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

☐ Yes -----→ Go to question 11

☐ No headaches in temple area -----→ **SKIP** to question 13

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

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

12. **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

The following questions ask **your opinion** about the treatment that was recommended to you by your current dentist for your **jaw or temple** pain in the last 30 days.

13. How much has the treatment **relieved** your pain?

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

14. How much has the treatment i**mproved** your ability to use your jaw?

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

15. How **satisfied** are you with the treatment that you received?

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

16. How **easy** has it been to follow the treatment?

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

The following questions are for you to tell us about how your **recommended treatment** has affected your jaw or temple pain *and* any **side effects** you may have experienced from these treatments.

Note: A **mouth guard** may also be called a splint or oral appliance. **Medication** includes prescription medications and medications you get over the counter in a store without a prescription such as Tylenol or Advil. **Self-care** includes treatments you do to manage your pain like "resting your jaw, application of heat or cold, or changes in your diet."

17. **In the last 30 days**, did you do the following treatments **as recommended**?

Treatments	Not Recommended	Did as recommended
Wear a mouth guard when **awake**	☐	☐ Yes ☐ No
Wear a mouth guard when **eating**	☐	☐ Yes ☐ No
Wear a mouth guard when **sleeping**	☐	☐ Yes ☐ No
Medication	☐	☐ Yes ☐ No
Self-care	☐	☐ Yes ☐ No
Jaw exercises	☐	☐ Yes ☐ No
Care by physical therapist	☐	☐ Yes ☐ No
Care by chiropractor	☐	☐ Yes ☐ No
Care by psychologist, psychiatrist, counselor or social worker	☐	☐ Yes ☐ No

18. **In the last 30 days,** how much did the recommended treatments change your **pain**?

Treatments	Not Recommended **or** not seen yet	**Much worse**	**Slightly worse**	**No change**	**Slightly better**	**Much better**
Wear a mouth guard when **awake**	☐	☐	☐	☐	☐	☐
Wear a mouth guard when **eating**	☐	☐	☐	☐	☐	☐
Wear a mouth guard when **sleeping**	☐	☐	☐	☐	☐	☐
Medications	☐	☐	☐	☐	☐	☐
Self-care	☐	☐	☐	☐	☐	☐
Jaw exercises	☐	☐	☐	☐	☐	☐
Care by physical therapist	☐	☐	☐	☐	☐	☐
Care by Chiropractor	☐	☐	☐	☐	☐	☐
Care by psychologist, psychiatrist, counselor or social worker	☐	☐	☐	☐	☐	☐

19. **In the last 30 days,** did you experience any **unpleasant side effects** with the treatments as recommended?

Treatments	Not Recommended **or** not seen yet	No side effects	Yes, and I **kept doing** the treatment as recommended	Yes, and I did the treatment **less often** than recommended	Yes, and I **stopped** doing the treatment
Wear a mouth guard when **awake**	☐	☐	☐	☐	☐
Wear a mouth guard when **eating**	☐	☐	☐	☐	☐
Wear a mouth guard when **sleeping**	☐	☐	☐	☐	☐
Medications	☐	☐	☐	☐	☐
Self-care	☐	☐	☐	☐	☐
Jaw exercises	☐	☐	☐	☐	☐
Care by physical therapist	☐	☐	☐	☐	☐
Care by chiropractor	☐	☐	☐	☐	☐
Care by psychologist, psychiatrist, counselor or social worker	☐	☐	☐	☐	☐

20. **In the last 30 days,** how would you describe the **change** (if any) in your **jaw or temple pain**?

Much Worse	**Slightly Worse**	**No Change**	**Slightly Better**	**Much Better**
☐	☐	☐	☐	☐

21. **Since you enrolled in this study**, how many other professionals have you seen for your jaw or temple pain beyond those recommended by your dentist?

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

22. Would you like a brief summary of the results from this study emailed to you after the study is complete?

___ Yes
___ No

23. To improve future studies like this, we would like to learn about your experience with the study. Could we contact you to answer a one-time short survey about your experience? The additional questions will take no more than 5 minutes to complete.

___ Yes
___ No

Thank you for your time!