Advance Dental Arts Center
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Date: _____

Patient Name: _____
Last First Middle

Address: _____

_____

Telephone (home): _____ (work): _____

Age: _____ Date of Birth: _____ Sex: [ ] Male [ ] Female

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Number of Children: _____ Ages: _____

Are you presently employed? [ ] Yes, [ ] Full-Time [ ] Part-Time
[ ] No, [ ] Unemployed [ ] Disabled [ ] Retired

Occupation: _____

Who referred you to our clinic? _____

Referral Address and Phone: _____

_____

1. What is the main problem that brings you to this clinic? _____

_____

2. When did your problem begin? _____
(Date: month and year)

3. How did your problem begin?

[ ] Jaw Surgery	[ ] Blow to Jaw/ Head/ Neck	[ ] Motor Vehicle Accident
[ ] Chewing	[ ] Dental Work	[ ] Orthodontics (Braces)
[ ] Tooth Extraction	[ ] Stressful Situation	
[ ] Nothing; pain just came on		
[ ] Other: _____		

4a. What is the average severity of your pain? (Circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10

No pain Extreme pain

4b. What is the severity of your pain today? (Circle the appropriate number)

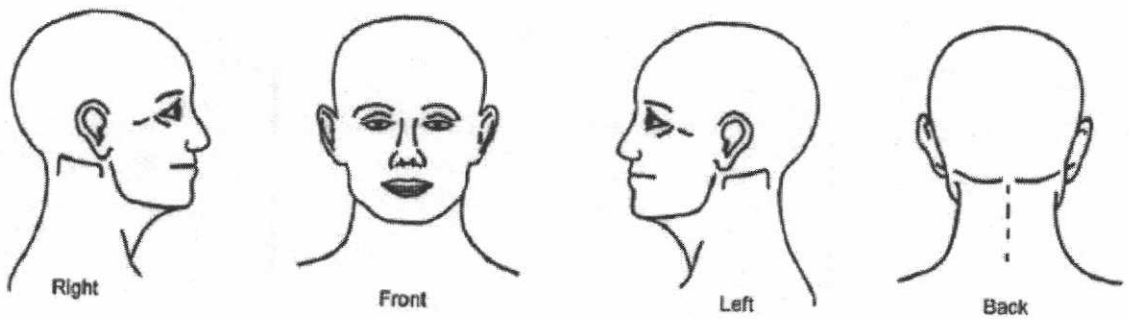
0 1 2 3 4 5 6 7 8 9 10

No pain Extreme pain

5. Describe the way your pain typically feels:

[ ] Throbbing	[ ] Gnawing	[ ] Spitting
[ ] Shooting	[ ] Hot / Burning	[ ] Tiring-Exhausting
[ ] Stabbing	[ ] Aching	[ ] Sickening
[ ] Sharp	[ ] Heavy	[ ] Fearful
[ ] Cramping	[ ] Tender	[ ] Punishing-Cruel

6. On the Diagram below please outline the areas where you feel your pain:



7. How long does the pain typically last?

[ ] Less than 1 minute	[ ] 1-10 minutes	[ ] Less than 1 hour
[ ] 1-5 Hours	[ ] 6-12 Hours	[ ] 13-24 Hours
[ ] Several Days	[ ] Constant	

8. Which of the following causes or aggravates the pain?

[ ] Chewing	[ ] Opening the mouth too wide	[ ] Hot/Cold Food or Drinks
[ ] Talking	[ ] Lack of Sleep	[ ] Damp or Cold Weather
[ ] Yawning	[ ] Playing a Musical Instrument	[ ] Stress/ Emotional Upset
[ ] Laughing	[ ] Riding in Car for long Periods	[ ] Sitting for Long Periods
[ ] Singing	[ ] Eating Certain Foods	[ ] Exercise

[ ] Other: _____

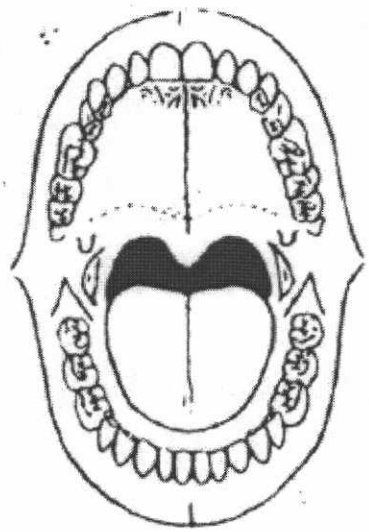
9. Which of the following relieves the pain?

[ ] Exercise	[ ] Massage of the area	[ ] Warm Soak/ Compresses
[ ] Heat	[ ] Holding jaw in a certain position	[ ] Ice/Cold compresses
[ ] Sleep	[ ] Moving/Manipulating the jaw	[ ] Pain Medication
[ ] Time	[ ] Relaxation	[ ] Nothing Helps

[ ] Other: _____

10. Do you have any painful teeth or other painful areas in your mouth?

[ ] Yes [ ] No If Yes, please circle the areas on the diagram



11. Check any of the following that you experience.

[ ] Numbness in the face or jaw	[ ] Weakness in jaw muscles
[ ] Earache	[ ] Ringing or buzzing of the ears
[ ] Ear Stuffiness	[ ] Dizziness
[ ] Neck Pain	[ ] Pain in back of the head
[ ] Back Pain	[ ] Morning Stiffness
[ ] Easily Fatigued	[ ] Jaw Catching
[ ] Aches and Pains all over body	[ ] Numbness/ Tingling in hands or fingers

12. Are you bothered by headaches?
[ ] Yes [ ] No If No, skip to number 13.

1) On average, how painful are your headaches?

0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

2) Do you have headaches as often as once per week?
[ ] Yes [ ] No

3) Do you have more than one type of headache?
[ ] Yes [ ] No

4) Do you wake up in the morning with a headache?
[ ] Yes [ ] No

5) Do you have headaches later in the day?
[ ] Yes [ ] No

6) Do headaches wake you from sleep?
[ ] Yes [ ] No

7) Is there any nausea or vomiting associated with your headaches?
[ ] Yes [ ] No

8) Is there vision changes associated with your headaches?
[ ] Yes [ ] No

If Yes, what kind? _____

9) What relieves the headache?
[ ] Rest [ ] Nothing
[ ] Sleep [ ] Exercise

[ ] Pain Medications, If so which ones? _____

13. Have you ever been in an accident or received a "blow" or injury to any part of your face, head, neck or back?
[ ] Yes [ ] No

If Yes, when? _____

Describe the circumstances: _____

_____

14. Are you aware of your jaw making sounds?
[ ] Yes [ ] No

If yes, please answer the following questions. If no, then go to question #15.

1) Which side? [ ] Right [ ] Left [ ] Both

2) Describe the nature of the sound:
[ ] Clicking [ ] Grating [ ] Popping [ ] Cracking

[ ] Other: _____

3) When do you notice the sounds?
[ ] Early opening
[ ] Middle opening
[ ] Wide opening
[ ] Moving jaw to the side
[ ] Chewing
[ ] While closing

4) Is the sound always present?
[ ] Yes [ ] No

5) Do you feel that the sounds are related to your pain?
[ ] Yes [ ] No

15. Has your jaw ever locked open?
[ ] Yes [ ] Right side [ ] Both sides
[ ] No [ ] Left side

Date of first occurrence? _____

If so, can you replace the jaw to normal position yourself?
[ ] Yes [ ] No

16. Have you ever been unable to open your mouth fully?
[ ] Yes [ ] No

17. How many times has your jaw locked open or closed during the past year?
[ ] None or # of times it has: _____

18. Do you have pain when your jaw locks open or closed?
[ ] Yes [ ] No

19. Do you chew gum?
[ ] Yes [ ] 0-25% of waking hours [ ] 25-50% of waking hours
[ ] No [ ] 50-75% of waking hours [ ] 75-100% of waking hours

20. Have you noticed any oral habits or practices that aggravate or cause pain?

[ ] Clenching the teeth [ ] Grinding the teeth
[ ] Chewing ice [ ] Chewing finger nails
[ ] Chewing pencil/ paper clips [ ] Chewing cheek/ lips
[ ] Holding phone between ear and shoulders
[ ] Playing wind instruments/ violin
[ ] Other: _____

21. Check all of the following that apply to you:

[ ] Feel I am under stress much of the time
[ ] Stress makes the pain worse
[ ] Do not enjoy my job
[ ] The pain prevents me from performing my normal activities
[ ] There are times when I feel as though I cannot breathe in enough air
[ ] My hands and feet are often cold or hard to keep warm
[ ] Feel depressed much of the time
[ ] Feel lightheaded or dizzy
[ ] Have been under the care of a psychiatrist or a psychologist

22. Check all of the following that apply to you:

[ ] Do not sleep well
[ ] The pain interferes with sleep
[ ] Awaken frequently during the night
[ ] Restless sleeper
[ ] Vivid dreams or nightmares
[ ] Go to bed more tired than daily activities justify
[ ] Do not feel rested in the morning

23. Do you feel that you usually eat a healthy, balanced diet?

[ ] Yes [ ] No

24. For each of the beverages listed below, write in the average number that you will drink each day:

Natural coffee:	_____ cups/day
Decaffeinated coffee	_____cups/day
Natural Tea	_____cups/day
Decaffeinated Tea	_____cups/day
Fruit juice	_____cups/day
Water	_____cups/day
Alcoholic beverage	_____drinks/cans/day
Soft drink	_____cans/bottles/day

Other (specify): _____cans/bottles/day