



TMD, Migraine, & Chronic Tension Headache Questionnaire

Please answer the following questions to the best of your ability, as detailed as possible, and if there is any information you feel we should know that is not specifically asked, please add it in the last section. Please bring this form to your consultation visit; should you have any questions about completing the form, please contact us, and we will be glad to assist you.

Patient Name: _____ Date: _____

What are the chief complaint(s) for which you are seeking treatment? (Circle all that apply)

Tension Headaches

Migraine Headaches

Jaw Pain

What sensations do you experience? (Circle all that apply)

Nausea

Light sensitivity

Noise sensitivity

Fatigue

Dizziness

Blurred Vision

When did your symptoms begin? _____

Was there a specific incident that seemed to trigger the symptoms? _____

Over time, have your symptoms? (Circle which is most appropriate)

Stayed relatively stable

Worsened/increased

Gotten better/decreased

Have you seen any of the following for evaluation and/or treatment? (Circle all that apply):

ENT

Neurologist

General Physician

Chiropractor

Massage Therapist

Physical Therapist

Previous Dentist

Homeopathic Physician

Alternative Medical Practitioner: _____

What types of tests have you had? (Circle all that apply):

MRI

CT Scan

X-ray

Blood Analysis

Allergy Testing

Other: _____

What types of treatments have you had? _____

Did you experience any relief? (Y) (N) Which treatment(s)? _____

How much? _____

How long did it last? _____

What are your symptoms now? _____

On a scale of 1-10, with 10 being the worst pain imaginable, what is your worst head pain? _____

How many days/week do you have pain that severe? _____

What is your AVERAGE daily head pain? _____

How many days/week do you wake up completely pain-free? _____

What percentage of time do you have at least some degree of pain? _____

At what time of day do you typically feel your worst pain? _____

What "number" (0-10) do you normally have when you awaken? _____

Please describe your pain? (ex: throbbing, squeezing, pressure, dull, shooting, etc...) _____

What % of the time do you have a "0" (no pain at all) without taking any medications? _____

Please list any/all medications (and dosages) that you currently take to prevent/control your headaches/pain? _____

What medications have you tried (and dosages) in the past to prevent/control your headaches? _____

Do the medications provide any relief? If so, please describe how much and for how long? _____

Symptoms: Please indicate location and type of head pain:

Key: L = Left R = Right B = Both sides Please Circle EITHER (L) or (R) or (B) for

		Severity			Frequency			Duration			
		Mild	Mod.	Severe	Occasional	Frequent	Constant	Min.	Hours	Days	Weeks
(L) (R) (B)	Front of head										
(L) (R) (B)	Back of head										
(L) (R) (B)	Side of head										
(L) (R) (B)	Entire head										

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc. to any referring or treating dentist or physician. I additionally authorize the release of any medical and/or dental information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment, regardless of insurance coverage as per Smiles by Payet Dentistry usual policies.

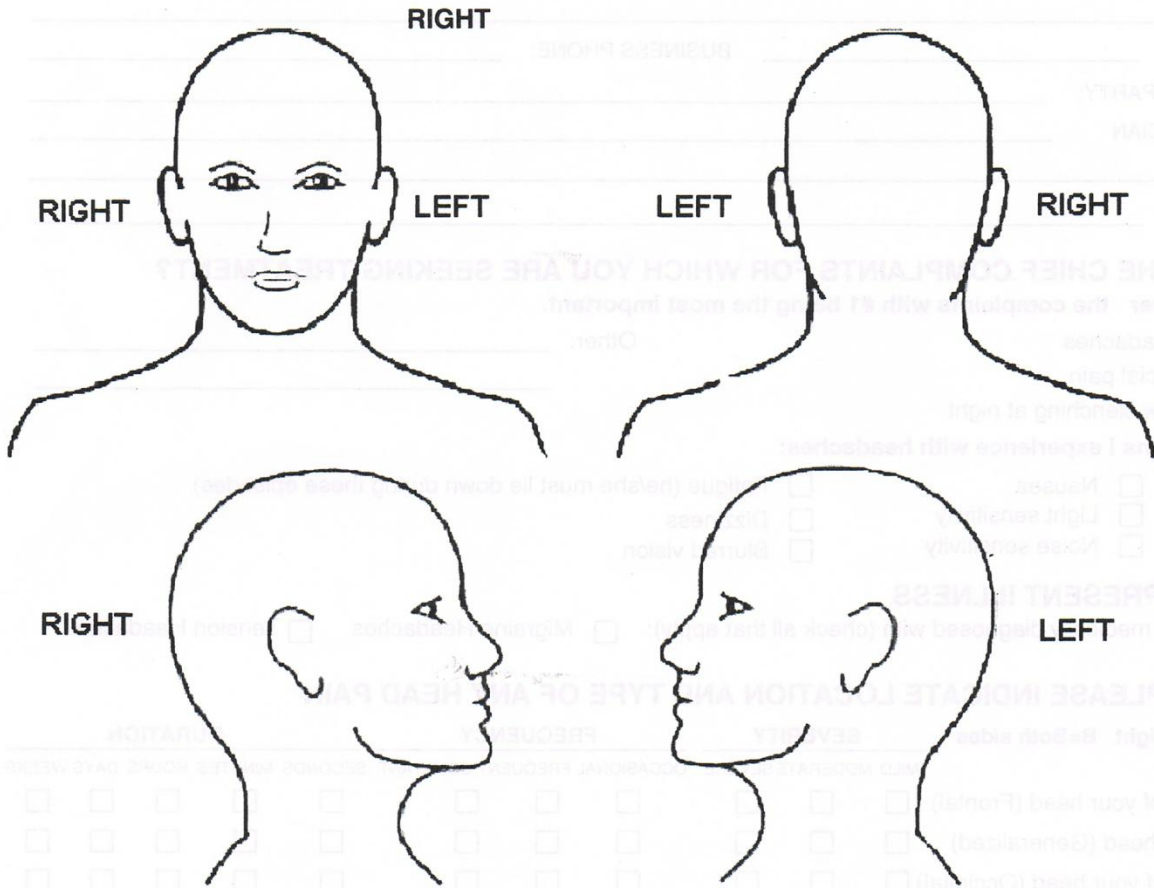
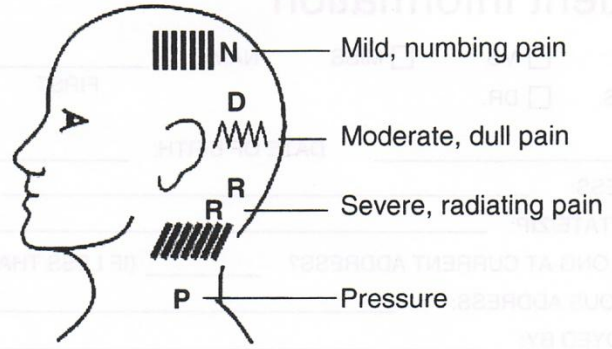
Patient Signature: _____

Date: _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

- | | | |
|---------------|---|-------------|
| MILD PAIN |  | B Burning |
| | | D Dull |
| | | N Numbing |
| MODERATE PAIN |  | P Pressure |
| | | S Sharp |
| | | T Tingling |
| SEVERE PAIN |  | R Radiating |

EXAMPLE



Patient Signature _____

Date _____

Please circle the response that best describes how you feel and calculate the totals below.



1. When you have headaches, how often is the pain severe?

- A) Never B) Rarely C) Sometimes D) Very Often E) Always

2. How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

- A) Never B) Rarely C) Sometimes D) Very Often E) Always

3. When you have a headache, how often do you wish you could lie down?

- A) Never B) Rarely C) Sometimes D) Very Often E) Always

4. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

- A) Never B) Rarely C) Sometimes D) Very Often E) Always

5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

- A) Never B) Rarely C) Sometimes D) Very Often E) Always

6. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

- A) Never B) Rarely C) Sometimes D) Very Often E) Always

