

**TMJ**  
**Head, Neck and Facial Pain**  
**Questionnaire**

*Please fill out form completely. Thank You*

**Michael Messing DDS MPH**  
**7 Short Hills Avenue**  
**Short Hills, NJ 07078**  
**973-921 -0771**

Date	/	/
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**PATIENT INFORMATION**

Patient's Name		Phone Number		
		Home	Work	Cell
Street Address		City	State	Zip
Age	Date of Birth / /	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Who may we thank for referring you?
Family Physician			Family Dentist	
In Case of Emergency, Who Should be Notified?			Relationship/Phone	

**PERSON RESPONSIBLE FOR ACCOUNT INFORMATION:**

Name	_____	Employer Name	_____
Address	_____	Employer Address	_____
City	State Zip	City	State Zip
Home Phone	SS#	Work Phone	_____

**PRIMARY MEDICAL INSURANCE INFORMATION:\***

Name of Insurance	_____	Name of Insured	_____
Address	_____	Insured's Date of Birth	_____
City	State Zip	Insured's Employer	_____
		Policy/ID#	Effective Date

**SECONDARY MEDICAL INSURANCE INFORMATION:\***

Name of Insurance	_____	Name of Insured	_____
Address	_____	Insured's Date of Birth	_____
City	State Zip	Insured's Employer	_____
		Policy/ID#	_____

*\*We do not participate with any medical insurance programs. Insurance information is for patient reimbursement purposes only.*

Signature of Patient,  
 Parent, or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Signature of Insured \_\_\_\_\_

Date \_\_\_\_\_

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

(Please order *YOUR* chief complaints by number, with "1" being most important)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Back Pain               | <input type="checkbox"/> Jaw Clicking          | <input type="checkbox"/> Pain Behind Eyes    |
| <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Jaw Joint Noises      | <input type="checkbox"/> Pain When Chewing   |
| <input type="checkbox"/> Ear Pain                | <input type="checkbox"/> Jaw Locking           | <input type="checkbox"/> Ringing in the Ears |
| <input type="checkbox"/> Ear/Sinus Congestion    | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Shoulder Pain       |
| <input type="checkbox"/> Facial Pain             | <input type="checkbox"/> Limited Mouth Opening | <input type="checkbox"/> Throat Pain         |
| <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Muscle Twitching      | <input type="checkbox"/> Tinnitus            |
| <input type="checkbox"/> Headaches               | <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Inability To Open Mouth | <input type="checkbox"/> Other _____           |  |

LIST TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING

	Practitioner	Specialty	Treatment & Approx. Date
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN *ALLERGIC REACTION*

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Antibiotics  | <input type="checkbox"/> Latex                 | <input type="checkbox"/> Plastic        |
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Local Anesthetics     | <input type="checkbox"/> Sedatives      |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Metals                | <input type="checkbox"/> Sleeping Pills |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Penicillian           | <input type="checkbox"/> Sulfa Drugs    |
| <input type="checkbox"/> Iodine       | <input type="checkbox"/> Other Allergans _____ |   |

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Antibiotics    | <input type="checkbox"/> Cortisone        | <input type="checkbox"/> Nerve Pills     |
| <input type="checkbox"/> Anticoagulants | <input type="checkbox"/> Diet Pills       | <input type="checkbox"/> Pain Medication |
| <input type="checkbox"/> Barbiturates   | <input type="checkbox"/> Heart Medication | <input type="checkbox"/> Sleeping Pills  |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Insulin          | <input type="checkbox"/> Sulfa Drugs     |
| <input type="checkbox"/> Codeine        | <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Tranquilizers   |
| <input type="checkbox"/> Other _____    |   |  |

ARE YOU PREGNANT?

Yes  No

IF YES, HOW FAR ALONG?

**THIS SPACE FOR OFFICE USE:**

## MEDICAL HISTORY

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Adenoids<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arteriosclerosis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Autoimmune Disorders<br><input type="checkbox"/> Bleeding Easily<br><input type="checkbox"/> Blood Pressure- High<br><input type="checkbox"/> Blood Pressure- Low<br><input type="checkbox"/> Bruising Easily<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Chemotherapy<br><input type="checkbox"/> Chronic Fatigue<br><input type="checkbox"/> Cold Hands/Feet<br><input type="checkbox"/> Current Pregnancy<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Difficulty Concentrating<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Excessive Thirst<br><input type="checkbox"/> Fluid Retention<br><input type="checkbox"/> Frequent Cough<br><input type="checkbox"/> Frequent Illnesses<br><input type="checkbox"/> Frequent Stressful Situations<br><input type="checkbox"/> General Anesthesia<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Hearing Impairment<br><input type="checkbox"/> Other Medical/Dental History _____ | <input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Heart Disorder<br><input type="checkbox"/> Heart Pacemaker<br><input type="checkbox"/> Heart Palpitations<br><input type="checkbox"/> Heart Valve Replacement<br><input type="checkbox"/> Hemophilia<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hypoglycemia<br><input type="checkbox"/> Immune System Disorder<br><input type="checkbox"/> Injury to Face<br><input type="checkbox"/> Injury to Mouth<br><input type="checkbox"/> Injury to Neck<br><input type="checkbox"/> Injury to Teeth<br><input type="checkbox"/> Insomnia<br><input type="checkbox"/> Intestinal Disorders<br><input type="checkbox"/> Jaw Joint Surgery<br><input type="checkbox"/> Kidney Problems<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Meniere's Disease<br><input type="checkbox"/> Menstrual Cramps<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Muscle Aches<br><input type="checkbox"/> Muscle Shaking (Tremors)<br><input type="checkbox"/> Muscle Spasms or Cramps<br><input type="checkbox"/> Muscular Dystrophy<br><input type="checkbox"/> Needing Extra Pillows to Help Breathing at Night<br><input type="checkbox"/> Nervous System Irritability<br><input type="checkbox"/> Nervousness<br><input type="checkbox"/> Neuralgia | <input type="checkbox"/> Osteoarthritis<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Ovarian Cysts<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Poor Circulation<br><input type="checkbox"/> Prior Orthodontic Treatment<br><input type="checkbox"/> Psychiatric Care<br><input type="checkbox"/> Radiation Treatment<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Rheumatoid Arthritis<br><input type="checkbox"/> Scarlet Fever<br><input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> Sinus Problems<br><input type="checkbox"/> Skin Disorder<br><input type="checkbox"/> Slow-Healing Sores<br><input type="checkbox"/> Snoring<br><input type="checkbox"/> Speech Difficulties<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Swollen, Stiff or Painful Joints<br>Tendency For:<br><input type="checkbox"/> Ear Infections<br><input type="checkbox"/> Frequent Colds<br><input type="checkbox"/> Sore Throats<br><input type="checkbox"/> Tired Muscles<br><input type="checkbox"/> Tonsils Removed<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Tumors<br><input type="checkbox"/> Urinary Disorders<br><input type="checkbox"/> Wisdom Teeth (3rd Molar) Extraction<br><input type="checkbox"/> Yeast Infections |
|--|--|--|

### SYMPTOMS

*L=Left R= Right B= Both Sides*

<u>Location</u>			<u>Severity</u>			<u>Frequency</u>			<u>Duration</u>				
			MILD	MODERATE	SEVERE	OCCASIONAL	FREQUENT	CONSTANT	SECONDS	MINUTES	HOURS	DAYS	WEEKS
<b>Head Pain</b>													
L R B	Front of your head (Frontal)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Entire head (Generalized)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Top of your head (Parietal)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Back of your head (Occipital)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	In your temples (Temporal)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Jaw Pain

L R B    Jaw pain- upon opening    \_\_\_\_\_  
 L R B    Jaw pain- while chewing    \_\_\_\_\_  
 L R B    Jaw pain- at rest    \_\_\_\_\_

### Jaw Symptoms

Jaw clicks    \_\_\_\_\_  
 Jaw locks closed    \_\_\_\_\_  
 Jaw locks open    \_\_\_\_\_  
 Jaw popping    \_\_\_\_\_  
 Teeth clenching    \_\_\_\_\_  
 Teeth grinding    \_\_\_\_\_

## MEDICAL HISTORY (continued)

### Eye-Related Conditions

- L R B Blurred vision \_\_\_\_\_  
 L R B Double vision \_\_\_\_\_  
 L R B Eye pain \_\_\_\_\_  
 L R B Pain/Pressure behind eyes \_\_\_\_\_  
 L R B Photophobia (light sensitivity) \_\_\_\_\_

### Ear Related Conditions

- Buzzing in the ears \_\_\_\_\_  
 Ear congestion \_\_\_\_\_  
 Ear pain \_\_\_\_\_  
 Hearing loss \_\_\_\_\_  
 Pain behind ear \_\_\_\_\_  
 Pain in front of ear \_\_\_\_\_  
 Recurent ear infections \_\_\_\_\_  
 Tinnitus (ringing in the ear) \_\_\_\_\_

### Throat, Neck & Back Related Conditions

- Back pain- upper \_\_\_\_\_  
 Back pain- middle \_\_\_\_\_  
 Back pain- lower \_\_\_\_\_  
 Chronic sore throat \_\_\_\_\_  
 Constant feeling of a foreign object in throat \_\_\_\_\_  
 Difficulty swallowing \_\_\_\_\_  
 Limited neck movement \_\_\_\_\_  
 Neck pain \_\_\_\_\_  
 Hand/finger numbness \_\_\_\_\_  
 Other \_\_\_\_\_

- Sciatica \_\_\_\_\_  
 Scoliosis \_\_\_\_\_  
 Shoulder pain \_\_\_\_\_  
 Shoulder stiffness \_\_\_\_\_  
 Swelling in the neck \_\_\_\_\_  
 Swollen glands \_\_\_\_\_  
 Thyroid enlargement \_\_\_\_\_  
 Tightness in throat \_\_\_\_\_  
 Tingling hands/fingers \_\_\_\_\_  
 Wryneck \_\_\_\_\_

### Mouth & Nose Related Conditions

- Broken teeth \_\_\_\_\_  
 Burning tongue \_\_\_\_\_  
 Chronic sinusitis \_\_\_\_\_  
 Dry mouth \_\_\_\_\_  
 Frequent biting of cheek \_\_\_\_\_  
 Frequent snoring \_\_\_\_\_

### Lifestyle Related Conditions

- Currently under usual stress \_\_\_\_\_  
 Recent change in lifestyle \_\_\_\_\_  
 Recent change in work pattern \_\_\_\_\_

Do you drink 2 or more alcoholic beverages per day? Yes <input type="checkbox"/> No <input type="checkbox"/>	Substance Dependency? Yes <input type="checkbox"/> No <input type="checkbox"/> _____
Do you drink 4 or more cups of coffee per day? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you smoke tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/> _____
Does any family member have the same or similar problem? Yes <input type="checkbox"/> No <input type="checkbox"/>	

If yes, please explain \_\_\_\_\_  
 What makes your discomfort/pain worse? \_\_\_\_\_

## HISTORY OF SYMPTOMS

When did your condition first occur? \_\_\_\_\_

What do you believe is the cause of your pain or condition?

- Athletic endeavor   
  Fight   
  Fall   
  Accident   
  Heredity   
  Illness   
  Injury  
 Unknown   
  If accident, date \_\_\_\_\_  
 Other \_\_\_\_\_

What other information is important to your pain or condition? \_\_\_\_\_

DRAW YOUR PAIN PATTERNS  
FOLLOWING THIS KEY:

|||| MILD PAIN  
 ~~~~ MODERATE PAIN  
 SEVERE PAIN

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

EXAMPLE:

