Part I

Would you fill out the following personal information? Date: ………………

Name (with initials): ……………………………………………………………… 0 Male 0 Female

Date of birth: …………………………………………………… Telephone. 0………- ……..……..………

Address : …………………………………………………….…. Zip code: …………….……………

Location : ……………………………………………………………………………………...……..……..

Insured by : ……………………………………………………………………………………...…………

Marital status: 0 single 0 married/cohabiting 0 divorced 0 widowed

Your occupation? ………………………………………………………………………………………..………

What are your main complaints? (in order of importance)	When did this start?
1	
2	
3	
4	

Below are some symptoms listed. Can you specify in what order your symptoms occur? To do this, kindly number the symptoms. The one that first occurred you enter under 1 and the symptoms that arose subsequently you enter under 2 and so on until all the symptoms you have (or had) are numbered.

… mouth remains wide open	… locking of the jaws
… clicking of the jaws	… pain when the jaws are moving
… crepitation of the jaws	… limited movement of the lower jaw

Have you been previously treated for the symptoms for which you are now requesting advice or treatment: 0 yes 0 no

If yes, then please indicate below by whom:
0 dentist 0 dental surgeon
0 GP (general practitioner) 0 speech therapist
0 physiotherapist 0 ear, nose and throat specialist
0 psychologist 0 ………………………

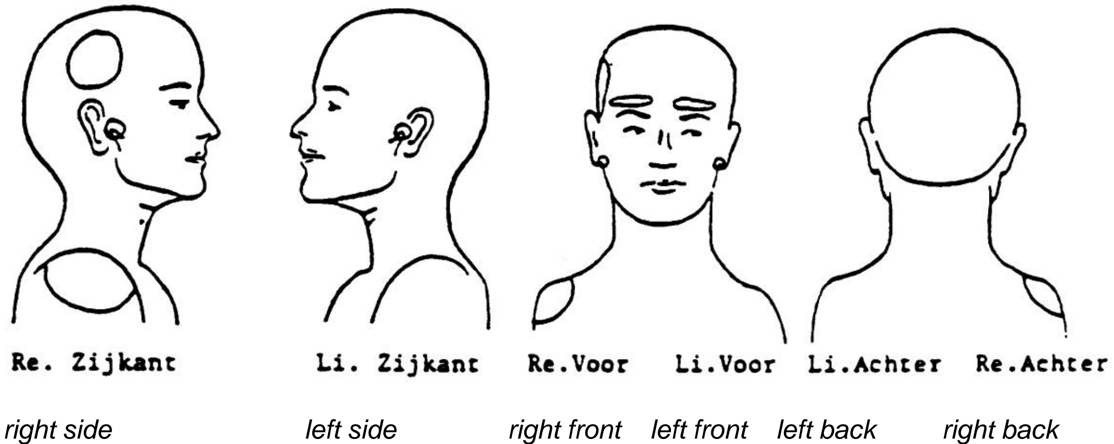
Which treatment was given?
0 splint
0 dental treatment/occlusal adjustment
0 exercises
0 …………..

Where x-rays made of your jaws? 0 yes 0 no

Many diseases can cause pain. The area where you regularly feel pain can provide information as to the possible cause of the pain. It is therefore important that we know exactly where that pain is located. Next are a set of questions in relation to pain that tend to occur in the jaw, head, neck and shoulder. *If you do not have any pain complaints in these areas please continue to part II on page 6.*

For a clear picture of where you experience regularly pain, the drawings below are used. These drawings indicate the left and right side, front and back of the head, neck and shoulder. In these drawings you can indicate where you experience pain on a regular basis. For clarity an example is given. In the example drawings it is indicated how you can express where you feel pain. For instance you feel pain in a small area above the eyes, oppressive painful feeling on the right side of the head and regular pain in the right side of your shoulder and your jaw.

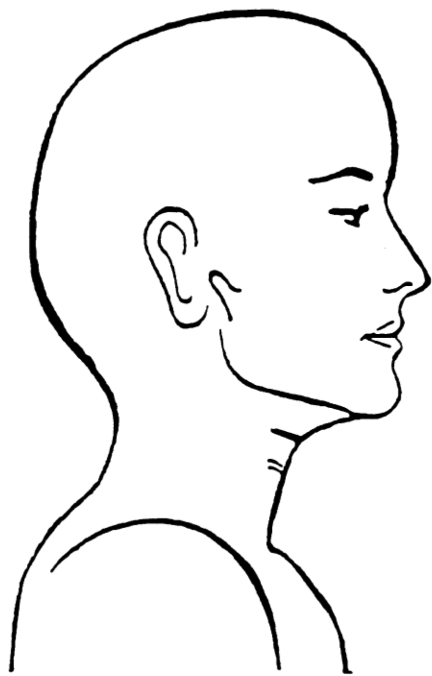
Example: *pain above the eyes, right or left side of the head, right shoulder and jaw*



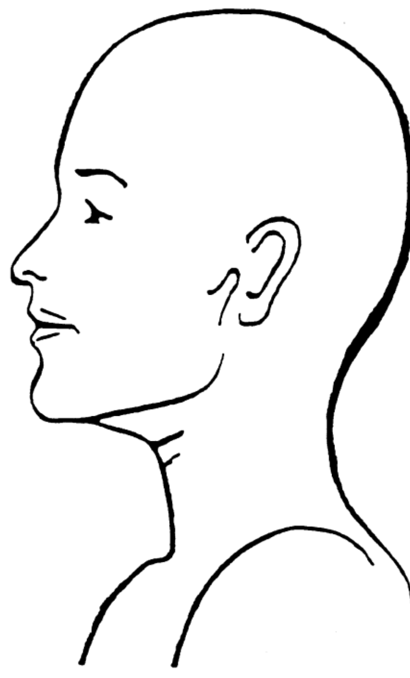
Please use the drawings on the next page to indicate by circling the area you experience pain and/or are sensitive. It is important that you do this as accurately as possible.

Please note not to confuse the left and the right side.

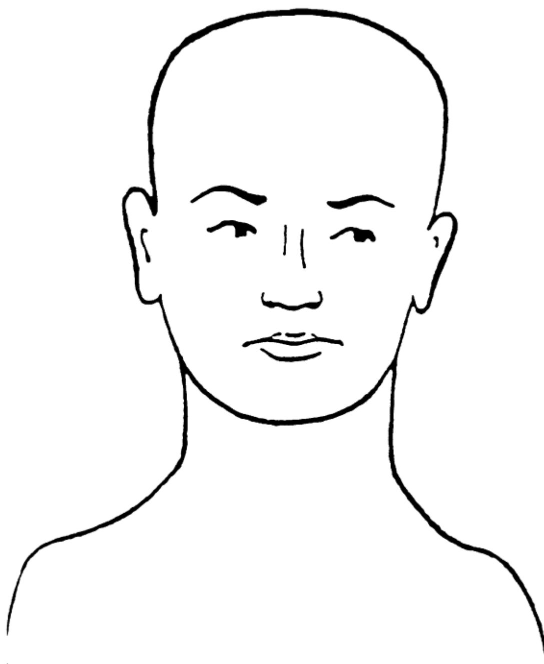
In the area you usually have the worst pain please indicate this by using number 1; if this pain almost goes together with the same intensity in other areas, also indicate these as number 1.
In other areas you experience less pain, please indicate this as number 2. If this pain goes together with pain or sensitivity of the same intensity in other areas, also indicate by using number 2.
Please repeat this process (indicating slightly lesser pain with numbers 3 and 4) in the area where this is experienced. On page 4 and 5 you will find questions which relate to the pain you have indicated as number 1.



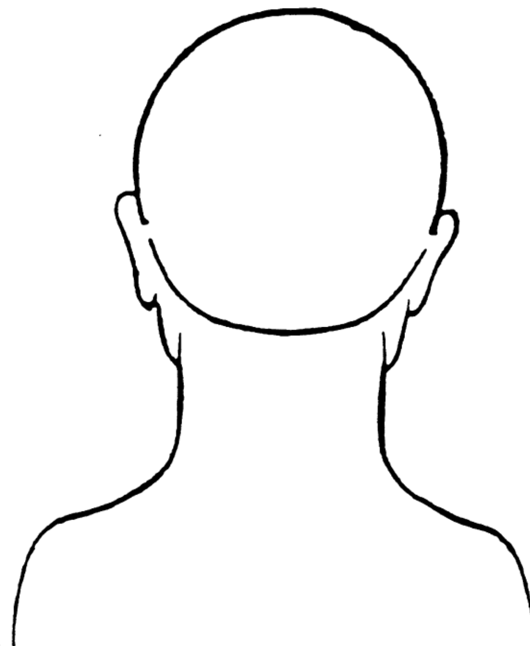
RE. ZIJKANT



LI. ZIJKANT



RE. VOOR LI. VOOR

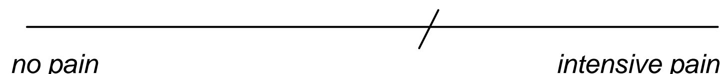


LI. ACHTER RE. ACHTER

Area 1

In order to get an indication of the level of pain you experience we use a horizontal line where you can indicate how bad the pain is. You can do that by placing a diagonal line on the vertical line (see example)

example:



no pain *intensive pain*

1. Please indicate below on the horizontal line with the use of a diagonal line the level of pain in your area 1?

no pain *intensive pain*

2. How long does the pain usually last?
   0 few seconds 0 few minutes 0 15 minutes 0 one hour 0 few hours
   0 one day 0 longer

3. How often do you experience pain?
   0 always 0 one or more times per day 0 one or more times per week
   0 one or more times per month 0 not that often

4. How long have you had these complaints?
   0 several days 0 1-3 weeks 0 1-5 months 0 6-11 months 0 1-2 years 0 longer

5. Over time have there been any changes in:
-number of times you have experienced pain in this area? 0 more often 0 less often 0 unchanged
-duration of the pain? 0 longer 0 less long 0 unchanged
-severity of the pain? 0 intense 0 less intense 0 unchanged
-the location of the pain? 0 yes 0 no

6. Do you experience radiation of pain from area 1 to other areas? 0 yes 0 no

7. Do you experience this pain on the left and right side? 0 yes 0 no
If yes, have you always experienced this? 0 yes 0 no
If no, on which side did the pain start? 0 left 0 right

8. Can you say whether the pain in area 1 usually occur simultaneously with pain in other areas (as you have indicated on the drawings with number 2, 3 and so one.)
If I feel pain in area 1, I generally also feel pain in the area(s) with number(s)
...……………………………………………………………………………………………………

9. Do you have any idea how the pain originated in this area? 0 yes 0 no
If yes, can you briefly indicate this?………………………………………………………………
……………………………………………………..……………………………………………
……………………………………………………………………………………………………..

10. How are you hampered in your work when you experience pain?
   0 not 0 somewhat 0 a lot 0 impossible to work

11. Can you indicate to what extent the following factors affect the pain you feel in area 1. This is done by indicating a "**0**" if there is no impact and by indicating "**+**" if the pain increases and "**-**" if the pain is reduced

… certain movements of your jaw … certain movements of your face … certain movements of your shoulder	… certain movements of your neck … after chewing … after speaking a long time
… cold … noise	… heat … bright light
… if you are feeling disappointed … if you are sad about something … if you are having doubts about something	… if you are nervous or restless … if you are dreading something … if you are worried
… physical exercise … mental exercise … if you did not sleep enough … if you slept too much	… resting/relaxing/at ease … massage … fatigue … you are reading

12. Have you discovered or learned ways to relieve or reduce pain in area "1" ? 0 yes 0 no
If yes, please specify……………………………………………………………………………………...
……….
……….

13. What part of the day do you often experience pain in area"1"?
0 morning 0 afternoon 0 evening 0 night

14. Do you have trouble falling asleep due to pain in this area?
0 never 0 sometimes 0 often 0 very often

15. Do you wake up at night from the pain in this area?
0 never 0 sometimes 0 often 0 very often

16. Do have this pain particularly on weekends?
0 yes 0 no

Part II

1. Are your jaws making a grinding sound when you move them?
   0 never 0 sometimes 0 often 0 very often

2. Are your jaws making a clicking sound when you move them?
   0 never 0 sometimes 0 often 0 very often

   If never, has this occurred in the past?
   0 never 0 sometimes 0 often 0 very often

3. Can you only open your mouth wide when you are using a certain movement with your lower jaw, whereby the jaw is making short clicking sounds? 0 yes 0 no

4. Have you experienced that your jaws are locked for more than a few seconds?
   0 never 0 sometimes 0 often 0 very often

   If so, how long does this locking usually last?
   0 few sec. 0 few min. 0 1 hour 0 1 day 0 1 week 0 always

   If you experience locking of your jaw can you undo this yourself?
   0 never 0 sometimes 0 often 0 always

5. Does your mouth sometimes stays wide open?
   0 never 0 sometimes 0 often 0 very often

6. Do you experience a stiff and/or tired feeling in your cheek or jaw muscles?
   morning/afternoon: 0 never 0 sometimes 0 often 0 very often
   daytime: 0 never 0 sometimes 0 often 0 very often

7. Do you experience trembling jaws or jaw muscles?
   0 never 0 sometimes 0 often 0 very often

8. Do you feel that you can open your mouth less than before? 0 yes 0 no

9. Do you feel pain if you open wide?
   0 never 0 sometimes 0 often 0 very often

10. Did you recently had to keep your mouth wide open (dentist visit or during anesthesia)?
    0 yes 0 no

    If yes, did the symptoms start at that time? 0 yes 0 no
    Did the procedure made your symptoms increase 0 yes 0 no

11. Do you grind or gnash your teeth?
    0 never 0 sometimes 0 often 0 very often

12. Do you clench you teeth vigorously?
    0 never 0 sometimes 0 often 0 very often

13. Do you bite or suck on:

-**lip, cheek and/or tongue**	0 never	0 sometimes	0 often	0 very often
-**chewing gum**	0 never	0 sometimes	0 often	0 very often
-**nails**	0 never	0 sometimes	0 often	0 very often
-**pen/pencil**	0 never	0 sometimes	0 often	0 very often

14. Do you participate in a specific sport and/or hobby? 0 yes 0 no
If yes, which sport and/or hobby?………………………………………………………………………….

15. For the following activities and functions of your jaw cab you indicate to what extent you are hampered by your symptoms/complaints.

-**biting something big (an apple)**
0 none 0 somewhat 0 pretty much 0 quite a lot
-**eating hard food**
0 none 0 somewhat 0 pretty much 0 quite a lot
-**eating of though food (toffee)**
0 none 0 somewhat 0 pretty much 0 quite a lot
-**eating soft food**
0 none 0 somewhat 0 pretty much 0 quite a lot
-**during work or daily activities**
0 none 0 somewhat 0 pretty much 0 quite a lot
-**yawning**
0 none 0 somewhat 0 pretty much 0 quite a lot
-**social activities (family, friends, entertainment etc.)**
0 none 0 somewhat 0 pretty much 0 quite a lot
-**speaking/talking**
0 none 0 somewhat 0 pretty much 0 quite a lot

16. Are you bothered/hampered by your complaints while trying to participate in sport and/or hobby?
0 yes 0 no

17. What is generally your sleeping position?
0 back 0 stomach 0 left or right side 0 varies greatly

18. Do you have a denture?
0 no 0 lower denture 0 upper denture 0 lower and upper denture
If yes, do you wear your denture at night?
0 no 0 only lower denture 0 only upper denture 0 lower and upper denture

19. Does your teeth make evenly contact when closing the jaws? 0 yes 0 no

20. Has the way in which your teeth fit together changed in recent years? 0 yes 0 no

Part III

1. Can you move your head well (turning/up and down)? 0 yes 0 no
   Are there limitations in movement of the head and/or neck? 0 yes 0 no
   Is movement painful? 0 yes 0 no
   Do you hear or experience sounds in your neck when moving your head? 0 yes 0 no

2. By moving your neck do you experience symptoms in head, arm or chest area? 0 yes 0 no
   If yes, what kind? 0 pain 0 dizziness 0 tingling 0…………………….........

3. Have you ever had an accident involving neck or head? 0 yes 0 no
   If yes, how many months ago? …………..…….months

4. Beside pain in area 1 as indicated in de drawings, do you suffer from headaches? 0 yes 0 no
   If no please continue to question 5.
   If yes, please answer questions below
   - -How many times you experience headaches?
     0 always 0 one or more times a day 0 one or more times a week
     0 one or more times a month 0 not that often
   - -In general, how long does the headache last?
     0 few seconds 0 few minutes 0 15 minutes 0 one hour
     0 several hours 0 one day 0 longer
   - -How would you describe the pain during the headache?
     0 nagging 0 stinging 0 dull 0 intense 0 pounding 0 throbbing
   - -Is there a connection in relation to:
     0 meals 0 exercise 0 menstruation 0 mental/psychological stress
     0 change of posture
   - -Do you suffer from the following symptoms during the headache attack:
     0 nausea 0 chills 0 a feeling of pressure in your head
     0 vomiting 0 dizziness 0 seeing flashes of light/stars/colored spots
     0 feeling pain when touching your head

5. In the last six months have you experienced the following symptoms?
   0 dizziness 0 nausea 0 eye problems 0 ear pain
   0 tinnitus 0 numbness in the ear 0 ear infection 0 sinusitis
   0 jaw sinusitis 0 nasal symptoms 0 throat symptoms 0 voice symptoms
   0 swallow symptoms 0 speech symptoms 0 swelling in front of the ear

6. Are you worried these symptoms might indicate something serious?
   0 yes 0 somewhat 0 no

7. -Do you work outside home? 0 yes 0 no
   -How many hours a week? ….…hours
   -Besides work are you most responsible for the household? 0 yes 0 no
   -Due to your pain, how many days in the last 12 months could you not do your daily tasks?
   ………days
   -How many days in the last 12 months could you not do your daily tasks due to <u>other</u> illness?
   ..……...days

8. Do you have a busy life? 0 yes 0 no

9. Have you suffered mental stress/burnout/nervous breakdown in the last two years?
   0 yes 0 no

10. Can you indicate if you suffer from:

-nervousness	0 never	0 sometimes	0 regularly	0 often	0 very often
-worrying	0 never	0 sometimes	0 regularly	0 often	0 very often
-annoyance	0 never	0 sometimes	0 regularly	0 often	0 very often
-apathy	0 never	0 sometimes	0 regularly	0 often	0 very often
-fear	0 never	0 sometimes	0 regularly	0 often	0 very often
-depression	0 never	0 sometimes	0 regularly	0 often	0 very often

11. How do you sleep in general?
    0 bad 0 tolerable 0 good 0 fine

12. In the last two years, did any significant changes in your private or work life occur? 0 yes 0 no
    If yes, can you specify?
    ………
    ………
    ………

13. Did events or situations occur recently that made you agitated, annoyed or that you found disappointing? 0 yes 0 no
    If yes, can you specify?
    ………
    ………
    ………

14. Are there problems in your family or direct environment that cause you a great deal of worries? 0 yes 0 no
    If yes, can you specify?
    ………
    ………
    ………

15. Can you indicate whether you agree with the following statements?

    -Doctors influence whether I am healthy or not.
    0 definitely agree 0 agree 0 somewhat agree
    0 somewhat disagree 0 disagree 0 definitely disagree

    -If I stay healthy is a matter of chance.
    0 definitely agree 0 agree 0 somewhat agree
    0 somewhat disagree 0 disagree 0 definitely disagree

    -It is primarily up to me how quickly I will cure from a disease or get better.
    0 definitely agree 0 agree 0 somewhat agree
    0 somewhat disagree 0 disagree 0 definitely disagree

Part IV

1. Have you been under treatment of a physician/specialist for other complaints 0 yes 0 no
   If yes, can you specify?
   ……
   ……..
   ……
   ….……………………………………………………………………………………………………..

2. What medication(s) do you use regularly?

medicine	started
1…………………………………….	……………………………
2…………………………….....…..	……………………………
3…………………………….....…..	……………………………
4…………………………….....…..	……………………………

3. Do you feel healthy at this moment? 0 yes 0 no

4. Do you have complaints in relation to the following:
   0 feet 0 ankle 0 knee 0 leg 0 thigh
   0 hip 0 hand 0 wrist 0 forearm 0 arm
   0 elbow 0 back 0 shoulder 0 neck

5. Do you experience following symptoms/conditions?

□ shortness of breath (dyspnoea)	□ coughing	□ asthma
□ bronchitis	□ pain in the joints	□ pain/tightness in the chest
□ irregular or fast heartbeat palpations	□ insensitive spots on the skin of the face	□ stomach ache
□ intestinal complaints	□ strong loss of weight	□ bad appetite
□ high blood pressure	□ low blood pressure	□ skin problems
□ allergy	□ epilepsy	□ rheumatism
□ diabetes		

6. In the last two years how many times did you have an operation?
   0 none 0 1-2 times 0 3-4 times 0 5-6 times 0 more than 7 times
   If so, could you indicate what kind of operations?
   ……
   ……
   ……

7. In the last two years how many days where you hospitalized?
   0 none 0 1-3 days 0 4-6 days 0 7-14 days 0 more than 15 days
   If so, could you indicate the reason?
   ……
   ……
   ……

8. Does one or more of the following conditions occur in your family?

□ jaw joint problems	□ other joint problems	□ rheumatism
□ frequent headaches	□ migraine	□ ……………………

9. Were x-rays taken in the last two years of your spine and/or other joints 0 yes 0 no
   If yes, can you specify?
   ……
   ……
   ……