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Musculoskeletal Screening Questionnaire:

PATIENT NAME: _____ DATE:_____

One OR More of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by checking the appropriate areas. (L=Left R=Right)

PART I:

a. Pain in the jaw joint ___L ___R
b. Pain in ear ___L ___R
c. Pain around eyes ___L ___R
d. Pain in lower jaw ___L ___R
e. Pain in upper jaw ___L ___R
f. Pain in neck ___L ___R
g. Pain in shoulders ___L ___R
h. Pain in forehead ___L ___R
i. Pain in temples ___L ___R
j. Pain in facial muscles ___L ___R
k. Facial muscle twitch ___L ___R
l. Subjective hearing loss ___L ___R
m. Clicking or popping sound in joint ___L ___R
n. Grating sound in joint ___L ___R
o. Dizziness (vertigo) ___Y ___N
p. Ringing sound in ears ___L ___R
q. Fullness, pressure blockage in the ear ___L ___R
r. Headache ___Y ___N
    1. Tension Headaches ___Y ___N
    2. Migraines ___Y ___N
    3. How Often? _____
    4. Top of Head ___L ___R
    5. Forehead ___L ___R
    6. Back of Head ___L ___R
    7. Temples ___L ___R
    8. Behind Eyes ___L ___R
s. Partial inability to open mouth ___Y ___N
    Constant _____
    Sporadic _____
t. Difficulty chewing ___Y ___N
u. Difficulty swallowing ___Y ___N
v. Pain in tongue ___L ___R

w. Difficulty breathing through nose ___Y ___N
x. Loud snoring ___Y ___N
y. Constantly tired ___Y ___N
z. Mouth breath at night ___Y ___N
aa. Awaken with a dry mouth ___Y ___N
If yes, 1. Frequently ____
2. Rarely ____
3. Never ____
bb. Loose teeth (specify) _____

PART II:

Occlusal Habits:

____ Clenching __AM __PM
____ Grinding on teeth __AM __PM
____ Teeth hit in front first
____ Cheek biting
____ Gum chewing
____ Pipe smoking
____ Pencil/Pen biting
____ Nail Biting
____ Other: _____

Postural Habits:

____ Phone cradling
____ Lean chin on hand
____ TV watching
____ Heavy lifting
____ Shoulder bags
____ Other:_____

PART III:

1. What are your chief complaints? List from most to least important:
   a. _____
   b. _____
   c. _____
2. Do symptoms affect one or both joints? R ____ L____ BOTH____
   If both joints, indicate which joint seems most affected: R____ L____
3. How many years, months, weeks or days have you been bothered by this problem?
   a. _____years b. _____months c. _____weeks d. _____days
4. Have you had any injury to the jaw or face? ___Y ___N
5. Do you have arthritis? ___Y ___N
6. Have you ever had cervical traction? ___Y ___N
7. Have you ever worn a neck brace? ___Y ___N
8. Have you had any other treatment for this problem? ___Y ___N
   If yes, explain—medicine, dental appliances i.e. splint, orthotic, or night guard:
   _____
9. Have you had your teeth straightened? (orthodontia) ___Y ___N
10. Have you had teeth removed for orthodontia? ___Y ___N
11. Have you had your wisdom teeth removed? ___Y ___N

12. Have you ever had general anesthesia? ___Y ___N
13. Did you have allergies as a child? ___Y ___N
14. Have you had your bite adjusted by your dentist? (equilibration) ___Y ___N
    If yes, explain when: _____
15. Do you attribute the symptoms to any one incident? ___Y ___N
    If yes, explain:
    _____
    _____
16. Have you had cortisone injected into your joint? ___Y ___N
    If yes, when? _____ How many injections? _____
17. Are you now on any medication? ___Y ___N
    If yes, what kind and how much?_____
18. Do you know if you clench your teeth? ___Y ___N
19. Has anyone mentioned that you grind your teeth (brux) at night during sleep?
    ___Y ___N
20. Do you chew gum? Frequently ___ Moderately ___ Never ___
21. Please list chronologically, names and types of doctors and their locations whom you have seen in the past for this or related problems. (Write on back of this sheet if necessary.)
    a. _____
    b. _____
    c. _____
    d. _____
22. In **YOUR** opinion, what initiated your present condition? (chief complaint)
    _____
    _____
    _____
    _____
    _____
23. What aspect of your condition concerns you the most?
    _____
    _____
    _____
24. Please tell us any other pertinent information that has not been covered previously in this questionnaire. Write on the back of this sheet if necessary.
    _____
    _____
    _____
    _____
    _____
25. Are you in litigation or are you planning litigation? ___Y ___N
    If yes, please explain:
    _____
    _____
    _____
    _____
    If yes, attorney's name, address, and phone:
    _____
    _____
    _____

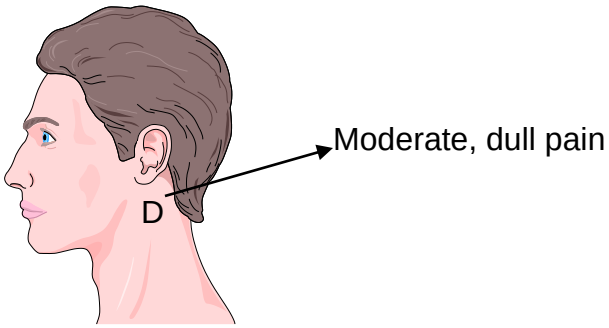
Draw your pain patterns by following this key:

MILD:

MODERATE:

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

Example:



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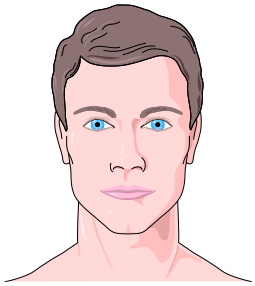

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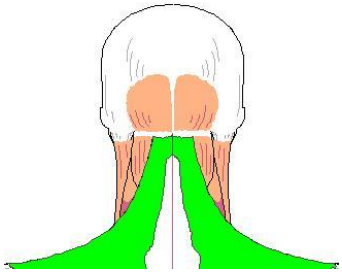
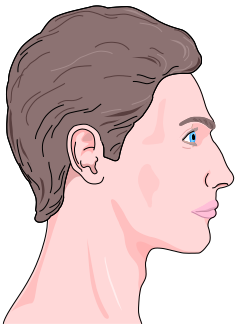


Right



Left