

Musculoskeletal Screening Questionnaire

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of these symptoms, please indicate by checking the appropriate area. (L=Left; R=Right)

Pain in jaw joint	___ L ___ R	Pain in tongue	___ L ___ R
Pain in ear	___ L ___ R	Partial inability to open mouth	___ L ___ R
Pain around eyes	___ L ___ R	If yes is it	
		Constant	___
		Sporadic	___
Pain in lower jaw	___ L ___ R		
Pain in upper jaw	___ L ___ R	Loud snoring	___ Yes ___ No
Pain in neck	___ L ___ R	Constantly tired	___ Yes ___ No
Pain in shoulder	___ L ___ R	Mouth breath at night	___ Yes ___ No
Pain in forehead	___ L ___ R	Awaken with a dry mouth	___ Yes ___ No
Pain in temples	___ L ___ R	If yes,	
Pain in facial muscles	___ L ___ R	Frequently	___
		Rarely	___
		Never	___
Grating sound in joint	___ L ___ R	Difficulty swallowing	___ Yes ___ No
Subjective hearing loss	___ L ___ R	Difficulty chewing	___ Yes ___ No
Clicking, snapping, or popping sounds in joint (underline which sounds more descriptive) If Present, is it in	___ L ___ R		
Dizziness (vertigo)	___ Yes ___ No		
Upset stomach-nausea	___ Yes ___ No		
Ring sound in ears	___ L ___ R		
Headache	___ L ___ R		
Fullness, pressure blockage in ear	___ L ___ R		

What are your chief complaints? List from most to least important

1 _____

2 _____

3 _____

Other symptoms?

Do symptoms affect one or both joints? Right ___ Left ___ Both ___

If both joints, indicated which joint seems more affected. R ___ L ___

How many years, months, weeks, or days have you been bothered by this problem?

Years ___ Months ___ Weeks ___ Days ___

Have you had any injury to the jaw or face? Yes ___ No ___

Do you have arthritis? Yes ___ No ___

Have you ever had cervical traction? Yes ___ No ___

Have you ever worn a neck brace? Yes ___ No ___

Have you had any other treatment for this problem? Yes ___ No ___

(If yes, explain – medicine, exercise, dental appliances such as a splint or night guard)

Have you had your teeth straightened (orthodontia)? Yes ___ No ___

Have you had teeth removed for orthodontia? Yes ___ No ___

Have you ever had your wisdom teeth removed? Yes ___ No ___

Have you ever had anesthesia? Yes ___ No ___

Did you have allergies as a child? Unknown ___ Yes ___ No ___

Have you had your bite adjusted by your dentist? (equilibration) Yes ___ No ___

Do you attribute the symptoms to any one incident? Yes ___ No ___

(If yes, explain) _____

Have you had cortisone injected into joint? Yes ___ No ___

If yes, when? _____ How many injections? _____

By whom? _____

Do you clench your teeth? Yes ___ No ___

Has anyone mentioned that you grind your teeth (brux) while you sleep? Yes ___ No ___

Do you chew gum? Frequently ___ Moderately ___ Never ___

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 the back of this sheet if necessary.

Please write in any other pertinent information that has not been covered previously. Write on the back of this sheet if necessary.

Are you in litigation or are you planning litigation? Yes ___ No ___

If so explain

Date _____ Patient Signature _____