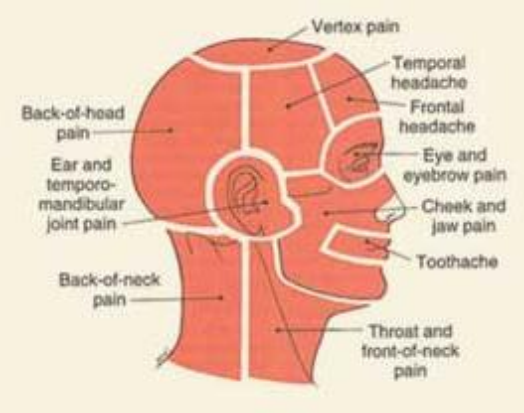
Pain Questionnaire

1. Where do you experience pain? Please mark the diagram below.
   For each location you mark please indicate L (left) or R (right) on the diagram



2. Do you experience headaches, neckaches or earaches? If so, please mark the location of these in the diagram above

3. When did your pain begin?
   _____

4. Look at the diagram above, in which part of your head, neck and face did you first experience pain?
   _____

5. Did the onset of your pain correspond with any event? (motor vehicle accident, fall, significant life event, dental procedure)
   _____

6. How would you describe the quality of your pain? (please circle **one or more** of the below)
   Aching, sharp, throbbing, pulsating, cutting, stabbing, shooting, burning, squeezing
   Other _____

7. Is your pain constant (that is always there to some extent) or does it come and go (that is, you have periods of no pain)?
   _____

8. If your pain is episodic (that is comes and goes with prolonged periods of no pain) does anything trigger your pain episodes? _____
   _____

9. If you pain is episodic, how long do the pain episodes last? - seconds, minutes, hours, days. You can circle more than one of these if appropriate?

10. When during the day do you experience your pain? (please circle **one or more** of the below)
    Upon waking, morning, afternoon, evening, night

11. When during the day is your pain at its worst? (please circle **one or more** of the below)
    Upon waking, morning, afternoon, evening, night

12. Does your pain interfere with your sleep?
    If yes, does it wake you from your sleep? Does it prevent you from falling asleep at night?
    _____

13. What is the severity of your pain? (please circle one of the below)
    Mild/moderate /severe

14. What makes your pain worse? (for example: stress, eating, yawning, chewing, talking, singing, etc)
    _____

15. What makes your pain better? (for example: heat, medications, sleep, rest)
    _____
    _____

16. Do you experience any of the following;
    a) Limited mouth opening – Yes/No
    b) Jaw locking – Yes/No
    c) Jaw joint sounds (click, pop, crack) – Yes/No
    d) Jaw tiredness – Yes/No

17. Do you clench your teeth or hold tension in your jaw? – Yes/No
    If so, do you do this at night, day or both? _____

18. Do you grind your teeth? – Yes/No
    If so, do you do this at night, day or both? _____

19. Do you experience any ear symptoms? (please circle one of the below)
    Pain, ringing, increased hearing, decreased hearing, dizziness, congestion

20. Does your pain interfere with any of the following daily activities? If so, to what extent?
    a) Work – Yes/No, _____
    b) Recreation/leisure– Yes/No, _____
    c) Exercise– Yes/No, _____
    d) Socialising– Yes/No, _____
    e) Relationships – Yes/No, _____
    f) Eating– Yes/No, _____
    g) On a scale of 1 – 10, to what extent does your pain interfere with your daily functioning _____

21. Do you have a history of long standing stress, anxiety or depression? Are you using any medications for either of these?
    _____

22. Have you experienced any major, long standing stressful events during your life?
    This may include but is not limited to: divorce, death of a loved one, serious illness of a loved one, financial problems, abuse (physical, emotional, sexual), significant problems with children

23. What is the nature of your work?
    _____

24. Have you had any treatment for your problem in the past? (please circle one or more of the below)
    Medications/drugs, physiotherapy, osteopathy, chiropractic, massage, acupuncture, dental splint/mouth guard, jaw exercises, jaw resting instructions.

25. Have any of the above treatments been helpful?
    _____

26. Do you experience chronic pain elsewhere in your body? If yes, please list these locations
    _____

27. Are you receiving treatment for the pain in these other areas of your body and if so what treatment?

    _____

28. Do you experience any of the following symptoms?
    a) Widespread pain throughout your body – Yes/No
    b) Widespread tenderness throughout your body – Yes/No
    c) Trouble sleeping – Yes/No
    d) Emotional distress – Yes/No
    e) Muscle tension (other than in and around your head/neck) – Yes/No
    f) Excessive daytime tiredness – Yes/No
    g) Snoring loudly– Yes/No
    h) Has anyone witnessed you stop breathing while asleep – Yes/No
    i) Have you ever been diagnosed with sleep apnoea? – Yes/No. Are you receiving any treatment for it – Yes/No
    j) Do you have a family history of OSA

    Office use only: BMI > 30, M or F, Neck circum > 40cm , Age > 50, Class 2, Mallampati 3 or 4, HT, smoking, alcohol, consider ESS

29. **If your age is 50 or older**, please circle the correct response:

    Yes ___ No ___ Does your facial pain occur when you eat?

    Yes ___ No ___ Do you have unexplainable scalp tenderness, for example when combing your hair?

    Yes ___ No ___ Are you experiencing unexplainable or unintentional weight loss?

    Yes ___ No ___ Do you have significant morning stiffness lasting more than ½ hour?

    Yes ___ No ___ Do you have visual symptoms or loss of vision?

    Yes ___ No ___ Have you recently developed any new headaches?

    Yes ___ No ___ Have you recently developed night sweats and/or fever

    Yes ___ No ___ Have you recently developed a loss of appetite