

Patient's Name _____ Date _____

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 the following symptoms, please indicate by checking the appropriate areas. (L = Left, R = Right)

- | | | | |
|----------------------------|------------------|------------------------------|-------------------|
| a. Pain in the jaw joint | <u> LR </u> | r. Headache | <u> YesNo </u> |
| b. Pain in ear | <u> LR </u> | Tension headaches | <u> YesNo </u> |
| c. Pain around eyes | <u> LR </u> | Migraines | <u> YesNo </u> |
| d. Pain in lower jaw | <u> LR </u> | How often? | <u> </u> |
| e. Pain in upper jaw | <u> LR </u> | Top of head | <u> YesNo </u> |
| f. Pain in neck | <u> LR </u> | Forehead | <u> YesNo </u> |
| g. Pain in shoulder | <u> LR </u> | Back of head | <u> YesNo </u> |
| h. Pain in forehead | <u> LR </u> | Temples | <u> YesNo </u> |
| i. Pain in temples | <u> LR </u> | Behind eyes | <u> YesNo </u> |
| j. Pain in facial muscles | <u> LR </u> | s. Partial inability to open | <u> YesNo </u> |
| k. Facial muscle twitch | <u> LR </u> | mouth If yes, (1) Constant | <u> </u> |
| l. Subjective hearing loss | <u> LR </u> | (2) Sporadic | <u> </u> |
| m. Clicking or popping | <u> LR </u> | t. Difficulty chewing | <u> YesNo </u> |
| sound in joint (circle | | u. Difficulty swallowing | <u> YesNo </u> |
| which sounds most | | v. Pain in tongue | <u> YesNo </u> |
| descriptive | | w. Difficulty breathing | <u> YesNo </u> |
| n. Grating sound in joint | <u> LR </u> | through nose | |
| o. Dizziness (vertigo) | <u> YesNo </u> | x. Loud snoring | <u> YesNo </u> |
| p. Ringing sound in ears | <u> LR </u> | y. Constantly tired | <u> YesNo </u> |
| q. Fullness, pressure or | <u> LR </u> | z. Mouth breather at night | <u> YesNo </u> |
| blockage in the ear | | | |
- aa. Awaken with a dry mouth YesNo
 If yes, 1) Frequently
 2) Rarely
 3) Never
- bb. Loose teeth (specify) _____

Occlusal Habits:

- | | |
|---|---|
| <input type="checkbox"/> Clenching __AM__PM | <input type="checkbox"/> Grinding on teeth __AM__PM |
| <input type="checkbox"/> Teeth hit in front first | <input type="checkbox"/> Cheek biting |
| <input type="checkbox"/> Gum chewing | <input type="checkbox"/> Pipe smoking |
| <input type="checkbox"/> Pencil biting | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Other: _____ | |

Postural Habits:

- | | |
|---|---|
| <input type="checkbox"/> Phone cradling | <input type="checkbox"/> Leans chin on hand |
| <input type="checkbox"/> TV watching | <input type="checkbox"/> Heavy lifting |
| <input type="checkbox"/> Shoulder bag | |
| <input type="checkbox"/> Other: _____ | |

1. What are your chief complaints? List from most to least important.
 - a. _____
 - b. _____
 - c. _____Other symptoms (please write in.) _____

2. Do symptoms affect one or both joints? Right__ Left__ Both__
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? Yes No
5. Do you have arthritis? Yes No
6. Have you ever had cervical traction? Yes No
7. Have you ever worn a neck brace? Yes No
8. Have you had any other treatment for this problem? Yes No
(If yes, explain-medicine, dental appliances such as a splint, orthotic, or night guard) _____
9. Have you had your teeth straightened (orthodontia)? Yes No
10. Have you had teeth removed for orthodontia? Yes No
11. Have you had your wisdom teeth removed? Yes No
12. Have you ever had general anesthesia? Yes No
13. Did you have allergies as a child? Yes No
14. Have you had your bite adjusted by your dentist?
(equilibration) If yes, explain when. _____
15. Do you attribute the symptoms to any one incident? Yes No
If yes, explain _____
16. Have you had cortisone injected into your joint? Yes No
If yes, when? _____ How many injections? _____
17. Do you chew gum? Yes No

18. 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.

<u>Date visited</u>	<u>Name</u>	<u>Type</u>	<u>Address</u>
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19. In your opinion, what initiated your present condition (chief complaint)?

20. What aspect of your condition concerns you most?

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