MUSCULOSKELETAL SCREENING QUESTIONAIRE

Date_____

Name_____ **Date of Birth**_____

Address_____

Referred by_____

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 circling the appropriate areas. (L= Left; R = Right)

a. Pain in jaw joints ___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 shoulder ___L R___

h. Pain in forehead ___L R___

i. Pain in temples ___L R___

j. Pain in facial muscles ___L R___

k. Grating sound in joint ___L R___

l. Subjective hearing loss ___L R___

m. Clicking, snapping, or Popping sound in joint underline which sounds most descriptive.) If present, is it in

n. Dizziness (Vertigo) ___L R___

o. Upset stomach-nausea ___L R___

p. Ringing sound in ears ___L R___

q. Headache ___L R___

r. Fullness, pressure blockage in ear ___L R___

s. Pain in tongue ___L R___

t. Partial Inability to open mouth ___L R___
if yes, is it (1) Consistent
(2) Sporadic

u. Difficulty chewing ___L R___

v. Difficulty swallowing ___L R___

w. Loud snoring ___L R___

x. Constantly tired ___L R___

y. Mouth breathe at night ___L R___

z. Awaken with dry mouth ___L R___

If yes, a) Frequent
b) Rarely
c) Never

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

   1. _____

   2. _____

   3. _____

   Other symptoms (please write in).

   _____

   _____

2. **Do symptoms affect one or both joints? Right ( ) Left ( ) Both ( )**

   If both joints, indicate which joint seems affected ___L ___R

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, exercise, dental appliances such as a splint, or night guard.)

   _____

9. **Have you had your teeth straightened (orthodontics)? ___ 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) ___ Yes No ___**

    (If yes please explain)

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

    (If yes explain)_____

    _____

16. **Have you had cortisone injected into joint? ___ Yes No ___**

If yes when? _____ How many injections? _____ By whom? _____

17. **Are you now on any medication?** **___ Yes** **No ___**

If yes, what kind and how much? _____

_____

18. **Do you know if you clench your teeth?** **___ Yes** **No ___**

19. **Has anyone mentioned that you grind your teeth (brux) at night during sleep?** **___ Yes** **No ___**

20. **Do you chew gum? Frequently ( )** **Infrequently ( )**

Moderate ( ) **Never ( )**

21. **Please list chronologically, names and type 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. _____

e. _____

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

_____
_____
_____
_____

23. **Are you in litigation or are you planning litigations?** **___ Yes** **No ___**

If so explain:

_____
_____
_____
_____

Date:_____ **Patient Signature :_____**