Name____Age________Date__________________

HEADACHE/JAW PAIN/MIGRAINE QUESTIONNAIRE

Please circle or write the number which best indicates your level of discomfort. **0 for no discomfort, 10 for severe**

1. How many mornings per week do you wake up with a "0" (you feel "great")? .... ________
2. What % of your time awake do you have some degree of headache? .... ________
3. What % of your time awake do you have zero pain without taking medications? .... ________
4. How many times per (circle) week/month might you experience your worst pain? .... ________
5. What is the average level of discomfort you usually wake up with?....................0 1 2 3 4 5 6 7 8 9 10
6. What is your average headache pain level throughout the day?.........................0 1 2 3 4 5 6 7 8 9 10
7. What is the worst pain level you experience? 0 1 2 3 4 5 6 7 8 9 10
8. I have (circle) buzzing, ringing, "stuffiness," or pain in or around my ears............0 1 2 3 4 5 6 7 8 9 10
9. My jaw joint makes noise when I chew...0 1 2 3 4 5 6 7 8 9 10
10. It hurts when I chew, open wide, or take a big bite....................................0 1 2 3 4 5 6 7 8 9 10
11. My jaw occasionally gets stuck so it's difficult to open or close.............................0 1 2 3 4 5 6 7 8 9 10
12. Certain teeth are sensitive, tender, or loose..0 1 2 3 4 5 6 7 8 9 10
13. I sometimes find myself clenching or grinding my teeth.......................................0 1 2 3 4 5 6 7 8 9 10
14. How often do you chew gum? .... ____________________
15. Have you ever been told that you grind your teeth at night?..............................yes no
16. My (circle) jaw, neck or upper back muscles are sore when I wake up.....................yes no
17. My headaches regularly occur, or are worse, when I wake up.............................yes no
18. Does the pain tend to occur at any other particular time of day? ....yes no When?_______
19. How many headaches do you get each month? ________When? ______________________________
20. The overall severity of my problem is...0 1 2 3 4 5 6 7 8 9 10
21. Please circle the types of health care providers you've seen for your problem:
    MD Neurologist ENT Internist Physical Therapist Chiropractor Dentist Other____________
    What was the diagnosis? ____
22. What medical tests have been performed regarding your headaches?
    CT scan MRI X-ray Blood analysis Other______________________________________
    What were the results? ____
23. What types of procedures or treatments (including dental) have you had regarding your headaches?
    Bite appliances Surgery Bite adjustments Other______________________________________
    How helpful were these? ____
24. What medications do you take, or have you taken, to prevent or treat your headaches?
    ____
    How effective are/were the medications____
25. Please describe your problem in your own words____
    ____

Shade in the areas below where you experience your discomfort