



Bruxism Questionnaire

Please Answer All Questions	Do Not Write In This Space
<p>1. Name _____ Age _____ Date _____ Referred by _____</p> <p>2. Which of the following do you have (circle all that apply)</p> <p>Headache Neck pain Jaw pain Ear pain Facial pain Other _____</p> <p>Which side hurts (circle one) Right Left Both Comments _____</p> <p>3. Place an (X) where you hurt.</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  Right Side </div> <div style="text-align: center;">  Left Side </div> </div> <p>4. How long have you had this pain? _____</p> <p>Is the pain constant? _____</p> <p>Is the pain (circle all that apply)</p> <p style="padding-left: 40px;">Aching Burning Stabbing</p> <p>Other _____</p> <p>5. Is the pain the worst in the (circle all that apply)</p> <p style="padding-left: 40px;">Morning Afternoon Evening Night</p> <p>6. Have you ever injured or sustained any form of trauma or whiplash to your (circle all that apply)</p> <p style="padding-left: 40px;">Jaw Head Neck</p> <p>(if so, please complete the trauma questionnaire)</p> <p>7. What makes the pain better? _____ _____</p> <p>What makes the pain worse? _____ _____</p>	

Your Name: _____

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<p>What medication(s) do you take or have you previously taken for your pain?</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; padding: 5px;">Medications</th> <th style="width: 30%; padding: 5px;">Dose</th> <th style="width: 40%; padding: 5px;">Frequency</th> </tr> </thead> <tbody> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black;"> </td> <td> </td> <td> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Medications	Dose	Frequency							
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<p>8. Dose it hurt to chew? Y N</p> <p style="padding-left: 20px;">Dose it hurt to open wide? Y N</p> <p style="padding-left: 20px;">Which side of your jaw makes a popping noise? L R</p> <p style="padding-left: 20px;">Which side of your jaw makes a clicking noise? L R</p> <p style="padding-left: 20px;">Which side of your jaw makes other noises? L R</p> <p style="padding-left: 20px;">What noises? _____</p> <p style="padding-left: 20px;">When did you first notice joint noises? _____</p>										
<p>9. Has your jaw ever locked? Y N</p> <p style="padding-left: 20px;">Did it lock open or closed? Open Closed</p> <p style="padding-left: 20px;">When did this first happen? _____</p> <p style="padding-left: 20px;">When did this last happen? _____</p> <p style="padding-left: 20px;">Has your jaw ever slipped out of place? Y N</p> <p style="padding-left: 20px;">Which side? R L</p>										
<p>10. Have you noticed a change in you bite? Y N</p> <p style="padding-left: 20px;">Did you notice a change at your front teeth? Y N</p> <p style="padding-left: 20px;">Did you notice a change at your back teeth? Y N</p> <p style="padding-left: 20px;">Has your profile changed? Y N</p> <p style="padding-left: 20px;">Have you notice any crookedness or asymmetry in your jaw? Y N</p> <p style="padding-left: 20px;">When did you notice the asymmetry? _____</p>										

