

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

