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Musculoskeletal Screening Questionnaire

	Name:			Date:		
	Date of Birth:	Date of Birth:		Phone:		
	Email:					
neck.	or more of the following sy	mptoms	may l	pe indicative of Musculoskeletal Dysfunction of the head oms, please indicate by circling the appropriate areas.		; R=
1.	Pain in jaw joints	L	R	17. Headache (Tension or Migraine)	L	R
2.	Pain in ear	L	R	18. Fullness, pressure, stuffiness		
3.	Pain around eyes	L	R	&/or blockage in ear	Υ	N
4.	Pain in lower jaw	L	R	19. Pain in tongue	Υ	N
5.	Pain in upper jaw	L	R	20. Partial inability to open mouth lf yes:	Υ	Ν
				Constant Sporadic	Y Y	N N
6.	Pain in the neck	L	R	21. Difficulty chewing	Υ	N
7.	Pain in shoulder	L	R	22. Difficulty swallowing	Υ	N
8.	Pain in forehead	L	R	23. Constantly tired or Insomnia	Υ	Ν
9.	Pain in temples	L	R	24. Loud snoring	Υ	Ν
10.	Pain in facial muscles	L	R	25. Mouth breathe at night	Υ	N
11.	Grating sound in joint	L	R	26. Awaken with dry mouth	Υ	N
12.	Difficulty with hearing	L	R	If yes:		
				Frequently	Υ	N
				Rarely	Υ	N
13.	Clicking or popping					
	sound in joint	L	R			

14.	Dizziness (vertigo)	Υ	١

15. Upset stomach-nausea Y N

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List additional symptoms?				
Do symptoms affect one or both joints?		R or	Both	
If both joints, which one is most affected?	L Days Y	R		
How long have you been bothered by this problem?		Weeks	Months	Yea
Have you had any injury to the jaw or face?		N		
If so, please briefly explain:				
Do you have arthritis?	Y	N		
Have you ever had general anesthesia?	Υ	N		
Have you ever had cervical traction?	Υ	N		
Have you ever worn a neck brace?	Υ	N		
Have you had your teeth straightened? (Orthodontia)	Υ	N		
Have you had your wisdom teeth removed?	Υ	N		
Did you have allergies as a child?	Υ	N		
Have you had your bite adjusted by a dentist (equilibrated)?	Υ	N		
If yes, please explain when and why:				
Do you clench your teeth?	Υ	N		
Do you grind your teeth (Brux) at night during your sleep?	Υ	N		
Do you chew gum?	Υ	N		
Frequently InfrequentlyModerately Never				
Do you attribute the symptoms to one incident?	Υ	N		

45.	Have you had cortisone injected into the jaw joint? Y N
	If yes, WhenHow many injections?
	By Whom:
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	Have you had any other treatment for any of the above issues? (medical, exercise, dental appliances
40.	splint or night guard).
47.	List all medications and dosage taken for these issues:
48.	Please list chronologically, names and types of doctors and their locations, whom you have seen in the past for this or related issues.
49.	Please indicate any other pertinent information which has not been covered previously.
50.	Are you in litigation or are you planning litigations? If so, please explain:
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	Date Completed: Patient's Signature: