Aesthetic Dentistry of Palm City

Welcome

TMJ SYNDROME AND MYOFASCIAL PAIN HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth/Age: _____

Sex: M or F (Circle One) SSN or SIN: _____

Address: _____ City: _____

State/Province: _____ Zip/Postal Code: _____

CHIEF COMPLAINT(S)

1.) Describe what you think the problem is: _____

2.) What do you think caused the problem? _____

3.) Describe, in order (first to last), what you expect from your treatment: _____

_____

MEDICAL AND DENTAL HISTORY

1.) Are you presently under the care of a physician or have you been in the past year? (circle one) Yes No

Physician's Name _____ Condition(s) Treated _____

_____

TREATMENT

1.) Name of medication(s) you are currently taking: _____

_____

2.) How would you describe your overall physical health? (circle one) Poor Average Excellent

3.) How would you describe your dental health? (circle one) Poor Average Excellent

Dentist Name: _____ Date of Last Appointment: _____

4.) Have you had any major treatment in the past two years? (circle one) Yes No

If Yes, please mark procedure(s): ☐ Orthodontics ☐ Periodontics ☐ Oral Surgery. ☐ Restorative

Date(s) of Third Molar (Wisdom Tooth) extraction(s): _____

HISTORY OF INJURY AND TRAMA

1.) Is there any childhood history of falls, accidents of injury to the face or head? (circle one) Yes No

Describe: _____

2.) Is there any recent history of trauma to the head or face? (Auto accident, sports injury facial impact) Yes No

Describe: _____

_____

3.) Is there any activity which holds the head or jaw in an imbalanced position? (phone, swimming, instrument) Yes No

Describe: _____

FACIAL PAIN PAST TREATMENT

1.) Have you ever been examined for a TMD problem before? (circle one) Yes No

If yes, by whom? When? _____

2.) What was the nature of the problem? (pain, noise, limitation of movement) _____

_____

3.) What was the duration of the problem? Months? Years?

Is this a new problem? (circle one) Yes No

4.) Is the problem getting better, worse or staying the same?

5.) Have you ever had physical therapy for TMD? (circle one) Yes No If yes, by whom? When? _____

_____

6.) Have you ever received treatment for jaw problems? (circle one) Yes No If yes, by whom? When? _____

_____

What was the treatment? (circle one) Bite Splint Medication Physical Therapy Occlusal Adjustment

Counseling Surgery Other (Please explain) _____

7.) Have you ever had injections for your TMD with muscle relaxants (Botox, Flexeril) cortisone or anti-inflammatories? Yes No

If yes, were they effective? (circle one) Yes No

CURRENT MEDICATIONS / APPLIANCES / TREATMENTS BEING USED (please circle)

	No Pain				**Moderate Pain**					**Severe Pain**	
1.) Degree of current TMD pain:	0	1	2	3	4	5	6	7	8	9	10

2.) Frequency of TMD pain: Daily Weekly Monthly Semi-Annually After Eating

Is the pain constant, continuous, or intermittent? _____ How long does it last? _____

What is the quality of the pain? (circle one) Sharp Dull Burning Aching Electrical Other _____

What makes it worse? _____

What makes it better? _____

How often does the pain occur? _____

Does the pain occur on it's own or do you need to trigger with function? (touching, etc.) _____

If you were to place a Q-tip in your left ear and push forward, does that trigger pain? _____

Can the pain be triggered by touching the skin with a light brush stroke with a Q-tip or pressing on an area with a Q-tip? _____

3.) Are you taking medication for the TMD problems? (circle one) Yes No If yes, what type? _____

How long? _____ Who prescribed the medication? _____

4.) Are the medications that you take effective? (circle one) Yes No Conditional? _____

5.) Are you aware of anything that makes your pain worse? (circle one) Yes No If yes, what? _____

_____

6.) Does your jaw make noise? (circle one) Yes No If so, when and how? _____

Right Side ☐ Clicking/Popping ☐ Grinding ☐ Other _____

Left Side ☐ Clicking/Popping ☐ Grinding ☐ Other _____

7.) Does your jaw lock open? (circle one) Yes No If so, when did this first occur? _____

How often? _____

8.) Has your jaw ever locked closed or partly closed? (circle one) Yes No If so, when did this first occur? _____

How often? _____

9.) Have any dental appliances bee prescribed? (circle one) Yes No If so, by whom? _____

When? _____ Describe: _____

When do you wear your dental appliances? _____

How many dental appliances have you worn? _____

10.) Are these appliances effective? (circle one) Yes No

11.) Is there any additional information that can help us in this area? _____

CURRENT STRESS FACTORS (PLEASE MARK EACH FACTOR THAT APPLIES TO YOU)

☐ Death of a Spouse	☐ Major Illness or Injury	☐ Major Health Change in Family
☐ Business Adjustment	☐ Divorce	☐ Pending Marriage
☐ Financial Problems	☐ Pregnancy	☐ Career Change
☐ Fired from Work	☐ Martial Reconciliation	☐ Taking on Debt
☐ Death of a Family Member	☐ New Person Joins Family	☐ Martial Separation

☐ Other _____

CURRENT AND PREVIOUS HABITS (PLEASE CIRCLE YOUR ANSWER TO EACH QUESTION)

1.) Do you clench your teeth together under stress?	Yes	No	Don't Know
2.) Do you grind/clench your teeth at night?	Yes	No	Don't Know
3.) Do you sleep with an unusual head position?	Yes	No	Don't Know
4.) Are you aware of any habits or activities that may aggravate this condition?	Yes	No	Don't Know

Describe: _____

CURRENT SYMPTOMS (PLEASE MARK EACH SYMPTOM THAT APPLIES)

A. HEAD PAIN, HEADACHES, FACIAL PAIN

☐ Forehead L R

☐ Temples L R

☐ Migrain Type Headaches

☐ Cluster Headaches Maxillary Sinus

☐ Headaches (Under the eyes)

☐ Occipital Headaches (back of the head (back of the head with or without shooting pain)

☐ Hair and/or Scalp Painful to the Touch

B. EYE PAIN / EAR ORBITAL PROBLEMS

☐ Eye Pain - Above, Below or Behind

☐ Bloodshot Eyes

☐ Blurring of Vision

☐ Bulging Appearance

☐ Pressure Behind the Eyes

☐ Light Sensitivity

☐ Watering of the Eyes

☐ Drooping of the Eyelids

C. MOUTH, FACE, CHEEK & CHIN PROBLEMS

☐ Discomfort

☐ Limited Opening

☐ Inability to Open Smoothly

CURRENT SYMPTOMS (PLEASE MARK EACH SYMPTOM THAT APPLIES) continued

D. TEETH & GUM PROBLEMS

- ☐ Clenching, Grinding at Night
- ☐ Looseness and/or Soreness of Back
- ☐ Teeth
- ☐ Tooth Pain

E. JAW & JAW JOINT (TMD) PROBLEMS

- ☐ Clicking, Popping Jaw Joints
- ☐ Grating Sounds
- ☐ Jaw Locking Opened or Closed
- ☐ Pain in Cheek Muscles
- ☐ Uncontrollable Jaw / Tongue Movements

F. PAIN, EAR PROBLEMS, & POSTURAL IMBALANCES

- ☐ Hissing, Buzzing or Ringing Sounds
- ☐ Ear Pain without Infection
- ☐ Clogged, Stuffy, Itchy Ears
- ☐ Balance Problems - "Vertigo"
- ☐ Diminished Hearing

G. NECK & SHOULDER PAIN

- ☐ Arm and Finger Tingling, Numbness, Pain
- ☐ Reduced Mobility and Range of Motion
- ☐ Stiffness
- ☐ Neck Pain
- ☐ Tired, Sore Neck Muscle
- ☐ Back Pain, Upper and Lower

H. THROAT PROBLEMS

- ☐ Swollowing Difficulties
- ☐ Tightness of the Throat
- ☐ Sore Throat
- ☐ Voice Fluctuations

I. OTHER PAINS

_____

_____

_____

_____

_____

_____

INFORMED CONSENT FOR TRIGGER POINT THERAPY

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor prior to signing the consent form.

THE TREATMENT

Trigger point injections (TPI) are used to treat extremely painful and tender areas of muscles. Normal muscle contracts and relaxes when it is active. A trigger point is a knot or tight band in the muscle that forms when muscle fails to relax. The knot often can be felt under the skin and may twitch involuntarily when touched (called a jump sign). The trigger point can trap or irritate surrounding nerves and cause referred pain - pain felt in another part of the body or in the teeth. Scar tissue and loss of range of motion and weakness may form over time. A small needle is inserted into the trigger point and a local anesthetic (e.g., lidocaine, procaine), botulinum toxin (e.g. Botox) or an anti-inflammatory steroid is injected. Trigger point injections have been found to be very effective in relieving pain, and may be used in combination with home exercise, heat, cold, and an individualized medication program.

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. 1. You may develop infection; 2.You may experience bleeding; 3.You may develop irritation at the injection site; 4.There may be skin changes; 5.You may develop bruising, redness or swelling; 6.The lung (or the pleura, which is the surrounding membrane) may be punctured if the procedure is performed in a muscle near the ribcage; and 7.The procedure may fail to reduce the pain symptoms. If any of these occur, additional surgery, prolonged hospitalization, and/or extended outpatient therapy to permit adequate treatment may be necessary. **Initial**_____

INFORMED CONSENT FOR TRIGGER POINT THERAPY

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to: myasthenia gravis, multiple sclerosis, Lambert-Eaton syndrome, amyotrophic lateral sclerosis (ALS), and Parkinson's. I do not have any allergies to lidocaine, botulinum toxin or to human albumin. **Initial**_____

PAYMENT

I understand that this in an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. **Initial**_____

RIGHT TO DISCONTIUE TREATMENT

I understand that I have the right to discontinue treatment at any time. **Initial** _____

RESULTS

Trigger point injections are used to alleviate myofascial pain syndrome (chronic pain involving tissue that surrounds muscle) that does not respond to other treatments. Many muscle groups, especially those in the arms, legs, lower back, and neck, are treated by this method. Trigger point injections can also be used to treat fibromyalgia, tension headaches, TMJ dysfunction, and other types of orofacial pain.

I understand this is an elective procedure and I hereby consent to treatment with trigger point injections for TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines.

I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure.

Patient Name **Patient Signature** **Date**