**Al Fallah, DDS., F.I.C.C.M.O**
**1293 Carlsbad Village Drive**
**Carlsbad, CA 92008 (760) 730-1600**

## MUSCULOSKELETAL SCREENING QUESTIONNAIRE

Date_____
Name_____Date of Birth_____
Address_____
Referred by_____

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by a scale of 1-10 with 10 being the worst. (L = Left, R = Right)

a. Pain in jaw joints ___L R___
b. Pain in ear ___L R___
c. Pain around eyes ___L R___
d. Pain in lower jaw ___L R___
e. Pain in upper jaw ___L R___
f. Pain in neck ___L R___
g. Pain in shoulder ___L R___
h. Pain in forehead ___L R___
i. Pain in temples ___L R___
j. Pain in facial muscles ___L R___
k. Grating sound in joint ___L R___
l. Subjective hearing loss ___L R___
m. Clicking, snapping, or popping sound in joint.(underline which sounds most descriptive) if present is it in ___L R___
n. Dizziness (vertigo) ___L R___
o. Upset stomach-nausea ___L R___
p. Ringing sound in ears ___L R___
q. Headache ___L R___
r. Fullness, pressure blockage in ear ___L R___
s. Pain in tongue ___L R___
t. Partial inability to open mouth. ___L R___
If yes, is it (1) Constant ( )
(2) Sporadic ( )
u. Difficulty chewing ___Yes No___
v. Difficulty swallowing ___Yes No___
w. Loud Snoring ___Yes No___
x. Constantly tired ___Yes No___
y. Mouth breather at night ___Yes No___
z. Awaken with a dry mouth ___Yes No___
If yes, a) Frequently ( ).
b) Rarely ( )
c) Never ( )

1. What are your chief complaints? List from most to least important.

1. _____
2. _____
3. _____

Other Symptoms (please write in).

_____

_____

2. Do symptoms affect one or both joints? Right ( ) Left ( ) Both ( )

If both joints, indicate which joint seems most affected ____L ____R

3. How many years, months, weeks or days have you been bothered by this problem?

a. _____ years b. _____ months c. _____ weeks d. ____ days

4. Have you had any injury to the jaw or face? ___Yes No___

5. Do you have arthritis? ___Yes No___

6. Have you ever had cervical traction? ___Yes No___

7. Have you ever worn a neck brace? ___Yes No___

8. Have you had any other treatment for this problem? ___Yes No___

(If yes, explain- medicine, exercise, dental appliances such as a splint, or night guard.)

_____

9. Have you had your teeth straightened (Orthodontia)? ___Yes No___

10. Have you had teeth removed for orthodontia? ___Yes No___

11. Have you had your wisdom teeth removed? ___Yes No___

12. Have you ever had general anesthesia? ___Yes No___

13. Did you have allergies as a child? Unknown___ No___

14. Have you had your bite adjusted by your dentist? (Equilibration) ___Yes No___

(If yes, please explain when)_____

15. Do you attribute the symptoms to any one incident? ___Yes No___

(If yes, explain)

_____

_____

16. Have you had cortisone injected into joint? ___Yes No___

If yes, when? _____ How many injections?_____

By whom? _____

17. Are you now on any medication? ___Yes No___

If yes, what kind and how much? _____

_____

18. Do you know if you clench your teeth? ___Yes No___

19. Has anyone mentioned that you grind your teeth (brux) at night during sleep? ___Yes No___

20. Do you chew gum? Frequently ( ) Infrequently ( )

Moderately ( ) Never ( )

21. Please list chronologically, names and types of doctors and their locations, whom you have seen in the past for this or related problems. Write on back of sheet if necessary.

a._____

b._____

c._____

d._____

e._____

22. Please write in any other pertinent information that has not been covered previously. Write on back of this sheet if necessary.

_____

_____

_____

_____

_____

23. Do you have sensitivity to any foods? If so, please list them. __Yes No__

_____

24. Do you run out of energy easily? If so, please describe your energy level patterns throughout the day.

__Yes No__

_____

_____

25. Do you have trouble falling sleep or staying sleep? __Yes No__

26. Are you in litigation or are you planning litigation? __Yes No__

If so, explain: _____

_____

_____

_____

_____

_____

Date: _____ Patient Signature_____