PAIN QUESTIONNAIRE

Name: _____ **Date:** _____

Please describe your problem: _____

_____

Where does it hurt? (Please circle all that apply): Upper Lower Right Left Front Back
Tooth Jaw Gums TMJ/jaw joint Other: _____

When did your symptoms begin? _____

_____

Are you aware of a specific incident that caused the pain to begin? _____

_____

When does it hurt? (Please circle all that apply): All the time Come and go Specific Trigger
Morning Afternoon Evening While Sleeping Other: _____

What triggers the pain? _____

_____

On a scale of 0-10 circle your level of pain? (0=no pain, 10 =worst pain you can imagine):

0-10 right now:	0	1	2	3	4	5	6	7	8	9	10
0-10 at worst:	0	1	2	3	4	5	6	7	8	9	10
0-10 average:	0	1	2	3	4	5	6	7	8	9	10

Please circle any that apply:

Cold sensitivity	Sharp/rough tooth	Headaches
Hot sensitivity	Broken tooth	Migraines
Lingering pain to hot/cold	Broken filling	Sinus infection/pain
Sweet sensitivity	Bleeding gums	TMJ/jaw joint pain
Chewing pain	Gum pain	Ear pain
Sharp	Bad taste	Neck pain
Dull	Bad smell	Recent dental treatment
Throbbing	Bad breath	Getting better
Pressure	Jaw pain	Getting worse
Shooting	Swelling	Staying the same
Unprovoked	Clench teeth	Controlled with medicine
Wakes you from sleep	Grind teeth	Not controlled with medicine