MUSCULOSKELETAL SCREENING QUESTIONNAIRE

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 appropriate area.

Pain in the jaw joint	Left/Right	HEADACHES	Yes/No
Pain in the ears	Left/Right	Tension headache	Yes/No
Pain around the eyes	Left/Right	Migraines	Yes/No
Pain in the lower jaw	Left/Right	Top of the head	Yes/No
Pain in the upper jaw	Left/Right	Forehead	Yes/No
Pain in the neck	Left/Right	Back of the head	Yes/No
Pain in the shoulder	Left/Right	Temples	Yes/No
Pain in the forehead	Left/Right	Behind the eyes	Yes/No
Pain in the temples	Left/Right	Awaken with a headache	Yes/No
Pain in the facial muscles	Left/Right	Your bite feels like it has changed	Yes/No
Facial muscle twitch	Left/Right	Difficulty chewing	Yes/No
Subjective hearing loss	Left/Right	Difficulty Swallowing	Yes/No
Clicking or popping sound in the jaw joints	Left/Right	Pain in the tongue	Yes/No
Grating sound in the jaw joints	Left/Right	Difficulty breathing through the nose	Yes/No
Ringing sound in the ears	Left/Right	Loud snoring	Yes/No
Excessive production of ear wax	Left/Right	Constantly tired or fatigue easily	Yes/No
Fullness, pressure or blockage in the ears	Left/Right	Mouth breather at night	Yes/No
Dizziness (Vertigo)	Yes/No	Nervousness/Insomnia	Yes/No
Awaken with a dry mouth	Yes/No	Partial inability to open the mouth Yes No If yes, is it Constant or Sporadic	Yes/No
Loose teeth (specify)	Yes/No	Blood shot eyes	Yes/No
Whiplash injury	Yes/No	Feeling of bulging eyes	Yes/No
Nauseous for no reason	Yes/No	Tearing of the eyes	Yes/No
Upset stomach/acid reflux	Yes/No	Sensitive eyes to light	Yes/No
Does food tend to get caught between your teeth	Yes/No	Postural problems with Hips, knees, pelvis, ankles, neck, back, specify	Yes/No
Sensitive teeth	Yes/No	Tingling in the fingertips day or night	Yes/No
Bells Palsy	Yes/No	Trigeminal neuralgia	Yes/No

Habits		Tooth Habits		Postural Habits	
Grinding of teeth	**Yes/No**	**Clenching**	**Yes/No**	**Phone cradling**	**Yes/No**
Cheek biting	**Yes/No**	**Teeth hit in the front first**	**Yes/No**	**TV watching**	**Yes/No**
Pipe smoking	**Yes/No**	**Gum chewing, does it affect your symptoms**	**Yes/No**	**Shoulder bag**	**Yes/No**
Nail biting	**Yes/No**	**Pencil biting**	**Yes/No**	**Other**	**Yes/No**
Lean chin on hand	**Yes/No**	**Other**	**Yes/No**		
Heavy lifting	**Yes/No**				

1. What are your chief complaints?
2. Do symptoms affect one or both joints? If both joints, indicate which joint seems most affected.
3. How many years, months, weeks or days have you been bothered by this problem?
4. Have you had an injury to the jaw or face?
5. Do you have arthritis?
6. Have you ever had cervical traction?
7. Have you ever worn a neck brace?
8. Have you had any other treatment for this problem? If yes please explain
9. Have you had teeth removed for orthodontics?
10. Have you had your wisdom teeth removed?
11. Have you had a general anaesthetic?
12. Did you have allergies as a child?
13. Have you had your bite adjusted by your dentist? If yes, explain why
14. Do you visit Chiropractors, Osteopaths or similar?
15. Missing back teeth with no replacement?
16. Tired jaws especially in the morning?
17. Have previous dentists had problems in getting you numb?
18. Do you attribute your symptoms to any one incident?
19. Have you had cortisone injected into your jaw joints? If yes, when? How many injections?
20. What aspect of your condition concerns you most or any other information?
21. Have you ever been involved in an accident or injury? Includes sports, serious slips or falls, ski accidents, car accidents? And did the symptoms start after this accident?