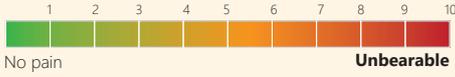


Orofacial Pain Questionnaire

NAME SURNAME: AGE

Initial Pain Assessment

1. Rate your current worst pain in the head, face and neck area. check the appropriate box



2. Frequency of Pain

- Constant (24/7) Seconds Minutes
- Hours Days
- Constant with varying intensity (constant background pain with "spikes" of intense pain)
- Intermittent (comes and goes)

3. Pain Quality

- Sharp Pressure-like/squeezing
- Electric Stabbing / lancinating
- Itching Hammering/pounding
- Dull Pins and needles
- Burning Throbbing/pulsating
- Aching Cramping
- Other:

4. Location of Pain

- Upper jaw The whole head
- Lower jaw "Like a band around my head"
- In/around/near ear Neck
- In/around/near eyes Scalp
- Forehead Inside the mouth
- Temple Other:

5. Does the pain occur or subside at night?

- Pain increases at night
- Pain decreases at night
- No difference

6. Are the symptoms worse?

- Morning Weekday
- During the day Weekend
- Evening No difference

Pain Onset and Influencing Factors

7. When did the pain first begin?

- <3 months 6 months to 1 year ago
- 3-6 months Over a year ago

8. What do you think started this pain?

- Injury Infection
- Dental procedure Unknown
- Stress Other:
- Physical exertion

9. Factors Increasing Pain

- Eating or chewing Weather changes
- Drinking / Swallowing Cold or hot weather
- Jaw movements (opening/closing/side to side) Stress / Mood
- Certain positions or movements Sleep problems
- Unergonomic working conditions (e.g. working in front of a computer / Long car trip)
- Other:

10. Factors Decreasing Pain

- Medication Exercise
- Rest Physiotherapy
- Heat or cold application Nothing seems to help
- Dietary changes Other:
- Good sleep

Radiologic Findings and Diagnoses

11. Have you had any radiologic exams/imaging studies? Were any of these conditions diagnosed recently?

- Caries / Decay
- Jaw infections/lesions/cysts/other
- Periodontitis
- Peri-implantitis
- Sinusitis
- TMJ erosion/effusion
- TMJ disc displacement
- Brain pathologies
- Neck pathologies
- I had exams, but I don't have a description
- None performed
- Other findings:

12. Have you been diagnosed with any of the following conditions (recently or in the past)

- TMJ disorders
- Bruxism
- Neuropathic pain/neuralgias
- Sinusitis
- Myofascial pain
- Obstructive sleep apnea (OSA)/snoring
- Other:

Specialist Consultations

13. Specialist Consultations During the Duration of Pain:

CHOOSE OUTCOME IF CONSULTED:

- | | | | | |
|-----------------------------------------------------|------------------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> IMPROVED | <input type="checkbox"/> NO CHANGE | <input type="checkbox"/> WORSENERD | | |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Neurologist | | | |
| <input type="checkbox"/> Maxillofacial Surgeon | <input type="checkbox"/> ENT Specialist | | | |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Rheumatologist | | | |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Endocrinologist | | | |
| <input type="checkbox"/> Physiotherapist /osteopath | <input type="checkbox"/> Other: | | | |

Diet, Lifestyle, and Supplements

14. Dietary Habits and Triggers:

Do specific foods trigger pain?

- YES NO NOT SURE

If yes, what food?

Have you tried any specific diets to manage the pain (e.g., elimination diets)?

- YES NO

If yes, what diet/food?

First meal time:

Last meal time:

15. Sleep Hygiene and Caffeine Consumption:

Do you maintain a consistent sleep schedule?

- YES NO

Are you refreshed upon waking?

- Usually yes Usually no

Do you sleep well? Describe the quality

- VERY POOR POOR AVERAGE GOOD EXCELLENT

How much caffeinated beverages (coffee/tea/coke /pepsi/Redbull, etc.) do you consume daily?

- non 1-2 Cups 3-5 Cups >5 Cups

The timing of the last cup of such beverage

- 1h or less before sleep Within 6h of bedtime
- More than six hours to bedtime

16. Supplementation

- Magnesium Vitamin D B-group Vitamins
- Other:

Psychological and Social Aspects

17. Have you experienced events that you feel have significantly impacted your life and well-being?

- YES NO

18. Do you feel anxious, depressed, or frustrated due to your pain?

- FREQUENTLY SOMETIMES RARELY NEVER

19. What methods do you use to cope with the pain?

- Psychotherapy
- Sport Medicines
- Social activity Relaxation Techniques
- Alcohol
- Other:

Additional Symptoms

20. Select the symptoms accompanying your pain

- Tearing eyes Balance disorders
- Nasal or sinus congestion Pain when turning the head
- Eye pain Dry mouth
- Visual disturbances Difficulty swallowing
- Tinnitus or ringing in the ears Pain when tilting the head
- Hearing loss None of the above
- Feeling of ear fullness

21. Do you clench your teeth or make unusual jaw movements during normal activities or work?

- YES NO

22. Do you feel that your bite is has changed?

- YES NO

Family and Medical History

23. Do you consider yourself to be in good health?

- YES NO NOT SURE

24. Do you have any autoimmune diseases or significant health conditions?

- YES NO NOT SURE

If yes, please specify

25. Does your family have a history of chronic pain disorders?

- YES NO If yes, please specify

26. Do you use oral appliances, such as night guards for bruxism?

- YES NO

So Far Received Pain Treatments

28. What pain reducing therapies have been used so far

Choose pain reducing therapy result if therapy took place

- | | | | | |
|-----------------------------------------|-------------------------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> IMPROVED | <input type="checkbox"/> NO CHANGE | <input type="checkbox"/> WORSENERD | | |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Orthodontic treatment | | | |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Heat/Cold Applications | | | |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Root Canal Treatment | | | |
| <input type="checkbox"/> Hypnosis | <input type="checkbox"/> TENS | | | |
| <input type="checkbox"/> Manual therapy | <input type="checkbox"/> Nerve blocks | | | |
| <input type="checkbox"/> Splint therapy | <input type="checkbox"/> Other | | | |

Additional Details

27. Are there any other symptoms or details you would like to add regarding your pain or condition?

- YES NO If yes, please specify

Understanding Why We Ask These Questions

This questionnaire helps us identify the causes and patterns of your pain to create a personalized treatment plan that provides relief. Understanding your symptoms, lifestyle, and medical history allows us to choose the best treatment methods for you.

Initial Pain Assessment

1. Rate Your Current Pain: Helps us determine the severity of your pain, which may require urgent intervention.
2. Frequency of Pain: Knowing if your pain is constant, variable, or intermittent helps us assess whether it's a chronic or acute issue.
3. Pain Quality: Descriptions like "burning" or "electric" suggest neuropathic pain, while "throbbing" may indicate vascular problems.
4. Location of Pain: Identifying where you feel pain (e.g., jaw, ear, temple) helps us pinpoint its source, such as TMD, migraines, or dental issues.
5. Pain at Night: Pain that worsens at night may indicate inflammation, or nocturnal teeth grinding/clenching.
6. Timing: Morning pain may result from nighttime clenching, while evening pain can be due to muscle fatigue caused by daily activities.

Pain Onset and Influencing Factors

7. Pain Onset: Knowing when the pain began helps us understand whether it is a new or chronic issue.
8. Pain Triggers: Factors like trauma, dental procedures, stress, or infections can trigger pain — identifying the cause helps with diagnosis.
9. Aggravating Factors: Activities like eating, drinking, jaw movements, or poor ergonomics can worsen pain. Understanding these helps tailor your treatment plan.
10. Relieving Factors: Knowing what alleviates your pain (e.g., rest, medications, heat/cold) can guide us towards the right diagnosis and treatment options.

Radiologic Findings and Diagnoses

11. Radiologic Exams: Information about previous imaging (e.g., MRI, X-rays) helps us avoid redundant tests and adjust your treatment.
12. Diagnosed Conditions: Understanding past diagnoses (e.g., bruxism, TMD, neuralgia) helps us better plan your therapy.

Specialist Consultations

13. Specialist History: Information about visits to specialists (dentists, neurologists, physical therapists) and their effectiveness helps us refine your treatment plan.

Diet, Lifestyle, and Supplements

14. Dietary Habits: Certain foods may trigger pain — if you notice this, we can suggest dietary changes.
15. Sleep & Caffeine: Poor sleep quality or excessive caffeine intake can exacerbate pain and teeth grinding.
16. Supplements: Magnesium or Vitamin D can affect muscle tension; understanding your supplementation helps us tailor our recommendations.

Psychological and Social Aspects

17. Life Events: Stressful events, especially diagnosed PTSD, can worsen pain — understanding this helps us provide better support.
18. Impact of Pain on Well-being: Anxiety, depression, or frustration can amplify pain perception; knowing this helps us adjust your therapy.
19. Coping Strategies: Information about your pain management methods (medications, relaxation techniques) helps us plan more effective strategies.

Additional Symptoms

20. Accompanying Symptoms: Symptoms like tinnitus, nasal congestion, or vision and balance disturbances may be related to your pain.
21. Jaw Movements & Clenching: Information about habits like clenching your jaw during work may indicate TMD.
22. Bite Alignment: Feeling that your bite is off may contribute to pain, although more often, changes in bite are a result of stress causing increased muscle tension and altered bite perception.

Health History and Treatment

23. General Health: Knowing about chronic conditions like diabetes or autoimmune diseases helps us plan your treatment.
24. Autoimmune Diseases: These can increase joint and muscle pain, requiring a specialized approach.
25. Family History: A family history of pain may influence your symptoms and require specific interventions.
26. Use of Oral Appliances: If night guards have not been effective, we may explore alternative guards or other treatment methods.

Previous Treatments

27. So Far Received Treatments: Information about previous treatments (e.g., acupuncture, medications, massage) helps us avoid repeating ineffective therapies and focus on new options.

Additional Information

28. Open-ended Question: Here, you can provide any additional information that may help us better understand your problem.