

# 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

1

2

3

4

5

6

7

8

9

10

No painUnbearable

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:

IMPROVED

NO CHANGE

WORSENER

☐ Dentist Neurologist

☐ Maxillofacial Surgeon ENT Specialist

☐ Psychiatrist Rheumatologist

☐ Psychologist Endocrinologist

☐ Physiotherapist /osteopath 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

☐ EXCELENT

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

IMPROVED

NO CHANGE

WORSENER

☐ Acupuncture Orthodontic treatment

☐ Medications Heat/Cold Applications

☐ Biofeedback Root Canal Treatment

☐ Hypnosis TENS

☐ Manual therapy Nerve blocks

☐ Splint therapy 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 .....

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# 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.