TMJ / HEADACHE QUESTIONNAIRE

Name: _____ Date (dd/mm/yy): _____

Please complete this questionnaire to best of your ability. The more information we have, the more likely we will be able to help you.

DAYTIME SLEEPINESS SCALE
For the following situations, answer with one of the following numbers:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION	SCORE
Sitting and reading	
Watching television	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
	TOTAL SCORE

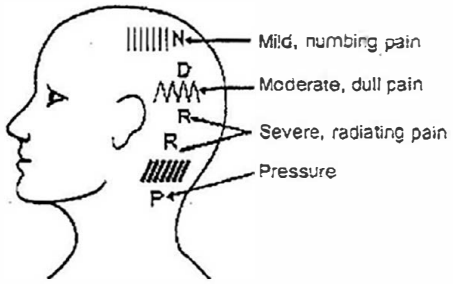
NIGHTTIME SLEEPINESS EVALUATION
Do you snore on most nights (>3 nights per week)?
☐ Yes ☐ No
Is your snoring loud? Can it be heard through a door or wall?
☐ Yes ☐ No
Has it ever been reported that you stop breathing or gasp during sleep?
☐ Never ☐ Occasionally ☐ Frequently
What is your collar size?
Male: ☐ Less than 17 inches ☐ More than 17 inches
Female: ☐ Less than 16 inches ☐ More than 16 inches

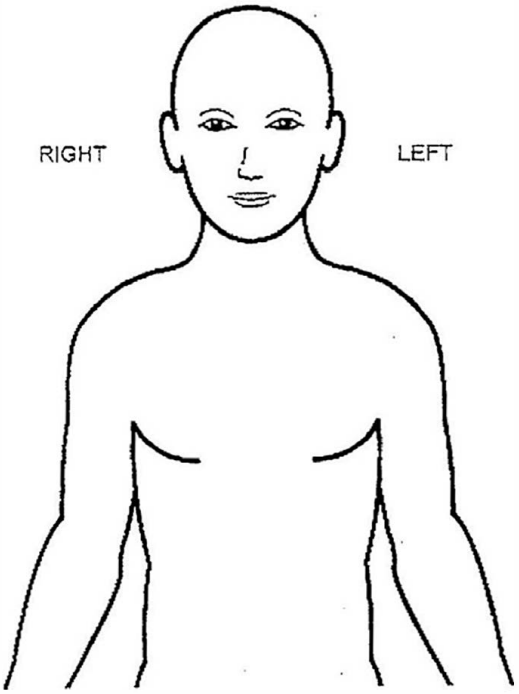
Do you occasionally fall asleep during the day when:
You are busy or active?
Yes ☐ No ☐
You are driving or stopped at a light?
Yes ☐ No ☐
Have you had or are you being treated for high blood pressure?
Yes ☐ No ☐

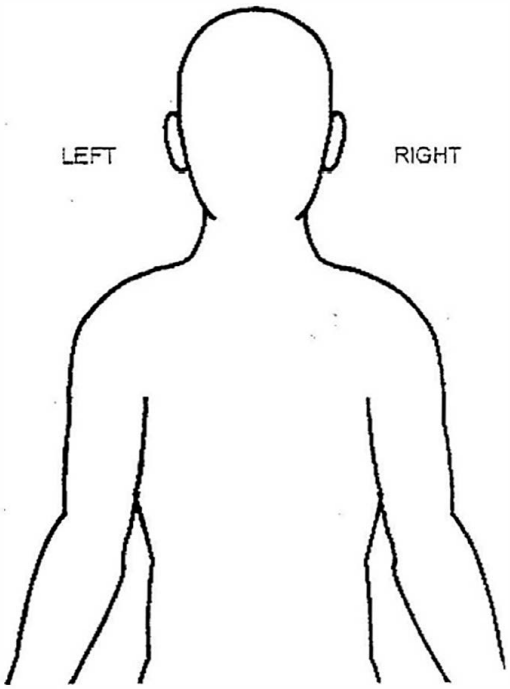
DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

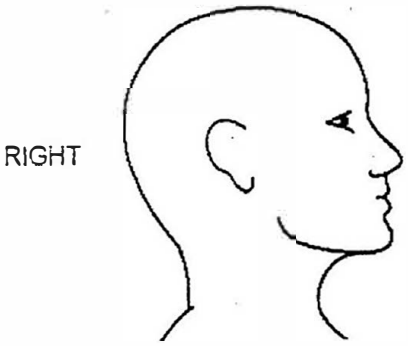
MILD PAIN		B Burning D Dull N Numbing P Pressure S Sharp T Tingling R Radiating
MODERATE PAIN		
SEVERE PAIN		

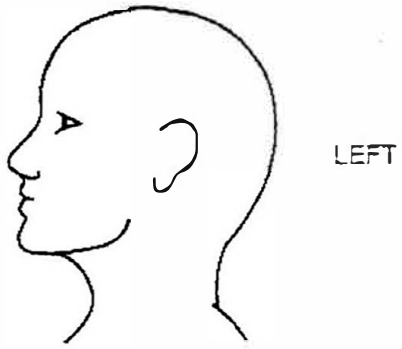
EXAMPLE











Signature: _____