

Dear Patient,

Please take your time and fill out this questionnaire to the best of your ability. Mail this back to our office when you are finished. Dr. Voorhees will review your information and then we will contact you to schedule an appointment. Dr. Voorhees initial TMJ exam will last at least 1 hour and the fee is \$289.00. This fee is NOT covered by your insurance. You will be expected to pay at the time of service. If you have any questions you may contact me at (913) 888-2474.

Thanks!

Sincerely,

Tara Bidding

# PATIENT REFERRAL QUESTIONNAIRE

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**Patient**

**Name** \_\_\_\_\_  
Last First Middle

**Address** \_\_\_\_\_  
Number Street  
City County State Zip

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_  
Can you be called at work? \_\_\_\_\_

**Sex:** M F **Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Marital Status:** \_\_\_ Single \_\_\_ Married/Living Together \_\_\_ Separated  
\_\_\_ Divorced \_\_\_ Widowed

**Name of Spouse/ Significant Other** \_\_\_\_\_

**In Case of Emergency Contact** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Occupation** \_\_\_\_\_ Full-time Part-time

**Spouse's Occupation** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Who referred you to our office?** \_\_\_\_\_

**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_  
Street City/State Zip

**The referring person is:** Physician Dentist Ph.D. Other \_\_\_\_\_

In addition to the referring person listed above, who else should receive a copy of your evaluation report? Please provide address and phone number.

\_\_\_\_\_ Dentist / Physician / Other  
\_\_\_\_\_ **Telephone** \_\_\_\_\_  
\_\_\_\_\_ **Fax #** \_\_\_\_\_

Is your pain complaint/ medical problem a result of an auto accident or a work-related injury?  
Yes No

**Patient Signature:** \_\_\_\_\_

1. Briefly describe your current pain problem. Why exactly are you seeking care?

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2. Circumstances under which your pain problem(s) began:

- a. \_\_\_\_ accident at work  
b. \_\_\_\_ accident at home  
c. \_\_\_\_ other accident  
d. \_\_\_\_ following illness
- e. \_\_\_\_ following surgery  
f. \_\_\_\_ at work (no accident)  
g. \_\_\_\_ at home (no accident)  
h. \_\_\_\_ no known cause  
i. \_\_\_\_ other \_\_\_\_\_

Briefly describe circumstances checked: \_\_\_\_\_

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3. What does your pain feel like? Some of the words below describe your present pain. Circle only those words that describe it. Leave out any category that is not suitable. Use only a single word in each appropriate category (the one that best applies).

A. Flickering  
Quivering  
Pulsing  
Throbbing  
Beating  
Pounding

B. Jumping  
Flashing  
Shooting

C. Pricking  
Boring  
Drilling  
Stabbing  
Lancinating

D. Sharp  
Cutting  
Lacerating

E. Pinching  
Pressing  
Gnawing  
Cramping  
Crushing

F. Tugging  
Pulling  
Wrenching  
Searing

G. Hot  
Burning  
Scalding  
Stinging

H. Tingling  
Itchy  
Smarting  
Aching

I. Dull  
Sore  
Hurting  
Splitting  
Heavy

J. Tender  
Taut  
Rasping

K. Tiring  
Exhausting

L. Sickening  
Suffocating

M. Fearful  
Frightful  
Terrifying  
Vicious

N. Punishing  
Grueling  
Cruel

O. Wretched  
Blinding

P. Annoying  
Troublesome  
Miserable  
Intense  
Unbearable




Q. Spreading  
Radiating  
Penetrating  
Piercing

R. Tight  
Numb  
Drawn  
Squeezing  
Tearful

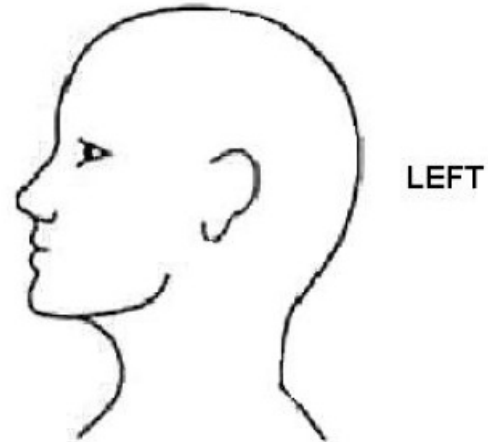
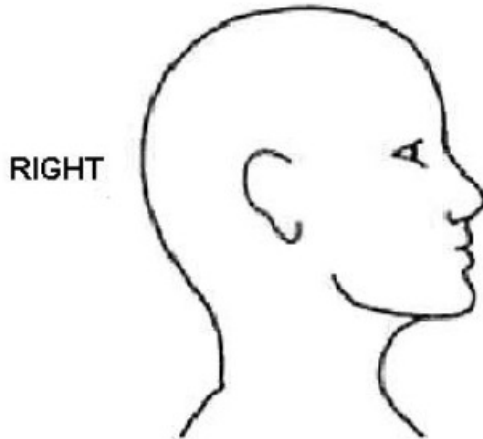
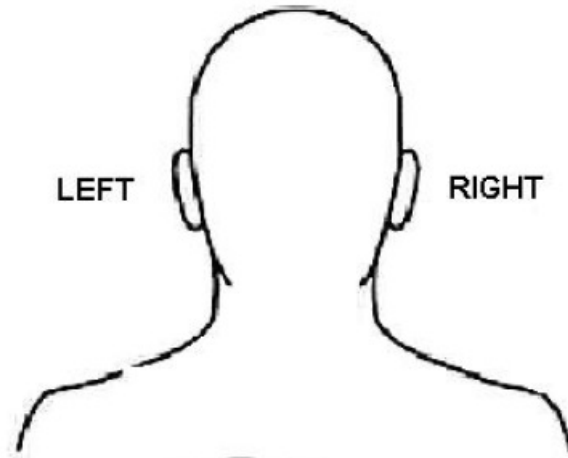
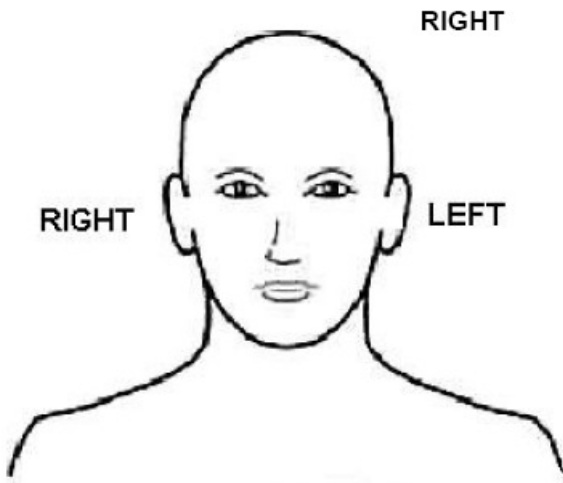
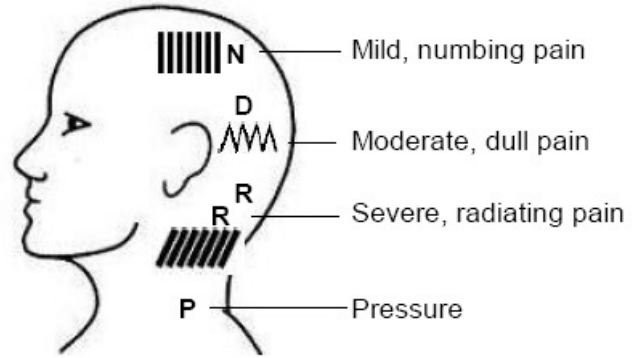
S. Cool  
Cold  
Freezing

T. Nagging  
Nauseating  
Agonizing  
Dreadful  
Torturing

**DRAW YOUR PAIN PATTERNS  
FOLLOWING THIS KEY:**

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

EXAMPLE



7. Each of the following questions is about your experience of pain. These questions can be answered by circling a word or words. If you wish to describe more than one head/face pain problem, list them individually in the area below (problems A, B, C, etc.), listing your worst pain first. These are called you **\*CHIEF COMPLAINT(S):** the problems for which you are seeking care here.

*\*NOTE: If you have only one significant pain or a chief complaint, list only one problem below. However, if you have several different pain complaints, list them separately.*

**PROBLEM A:** \_\_\_\_\_

<i>Intensity</i>	<i>Type of Pain</i>			<i>Frequency</i>	<i>Duration</i>		<i>Worst Time of Day</i>	
Mild	Sharp	Dull	Burning	_____ times/ day	Seconds	Minutes	Morning	Afternoon
Moderate	Aching	Shooting	Tingling	_____ times/week	Hours	Days	Night	Variable
Severe	Other _____			_____ times/month	Constant		While eating or talking	
					Variable		As the day progresses	

**PROBLEM B:** \_\_\_\_\_

<i>Intensity</i>	<i>Type of Pain</i>			<i>Frequency</i>	<i>Duration</i>		<i>Worst Time of Day</i>	
Mild	Sharp	Dull	Burning	_____ times/ day	Seconds	Minutes	Morning	Afternoon
Moderate	Aching	Shooting	Tingling	_____ times/week	Hours	Days	Night	Variable
Severe	Other _____			_____ times/month	Constant		While eating or talking	
					Variable		As the day progresses	

**PROBLEM C:** \_\_\_\_\_

<i>Intensity</i>	<i>Type of Pain</i>			<i>Frequency</i>	<i>Duration</i>		<i>Worst Time of Day</i>	
Mild	Sharp	Dull	Burning	_____ times/ day	Seconds	Minutes	Morning	Afternoon
Moderate	Aching	Shooting	Tingling	_____ times/week	Hours	Days	Night	Variable
Severe	Other _____			_____ times/month	Constant		While eating or talking	
					Variable		As the day progresses	

**PROBLEM D:** \_\_\_\_\_

<i>Intensity</i>	<i>Type of Pain</i>			<i>Frequency</i>	<i>Duration</i>		<i>Worst Time of Day</i>	
Mild	Sharp	Dull	Burning	_____ times/ day	Seconds	Minutes	Morning	Afternoon
Moderate	Aching	Shooting	Tingling	_____ times/week	Hours	Days	Night	Variable
Severe	Other _____			_____ times/month	Constant		While eating or talking	
					Variable		As the day progresses	

8. **The following lines represent pain of increasing intensity from no pain, to the most intense pain imaginable. Draw a mark on the line to best describe the intensity of your pain.**  
See Example

**Example:** If you have pain that is on average midway between no pain at all and the most severe pain you have ever experienced, then you should place a vertical mark midway on the line.

no pain \_\_\_\_\_|\_\_\_\_\_ most pain ever

**PLEASE COMPLETE THE FOLLOWING AS SHOWN IN THE EXAMPLE ABOVE:**

- A) Your average pain level:  
no pain \_\_\_\_\_ most pain ever
- B) Your pain at its worst:  
no pain \_\_\_\_\_ most pain ever
- C) Your pain at its least:  
no pain \_\_\_\_\_ most pain ever
- D) The following line represents pain on chewing. Mark the line depicting your pain level.  
no pain  
on chewing \_\_\_\_\_ can't chew

9. **Does your pain increase when you open wide?** YES NO  
Where? \_\_\_\_\_  
\_\_\_\_\_

10. **If your pain is not constant, what events are most likely to make it start (what brings it on)?**  
PROBLEM A \_\_\_\_\_  
PROBLEM B \_\_\_\_\_  
PROBLEM C \_\_\_\_\_  
PROBLEM D \_\_\_\_\_

11. **What is the most likely to make your general pain worse?**  
EXAMPLES: chewing, stress, sleep, talking, opening mouth wide, certain foods, weather, hot/cold food or drinks, exercise, lack of sleep, emotional upset, etc...

*List in order of severity (worst first)*

- PROBLEM A \_\_\_\_\_  
PROBLEM B \_\_\_\_\_  
PROBLEM C \_\_\_\_\_  
PROBLEM D \_\_\_\_\_

12. **What eases your general pain, or makes it better?**  
 EXAMPLES: medication, sleep, vacation, massage, exercise, hot or cold  
 compresses, relaxation, moving or holding jaw in a certain position

*List in order of effectiveness (most effective first)*

PROBLEM A \_\_\_\_\_  
 PROBLEM B \_\_\_\_\_  
 PROBLEM C \_\_\_\_\_  
 PROBLEM D \_\_\_\_\_

13. **Is there anything that can make your pain go away?** \_\_\_\_\_

14. **How long on average can you go without pain, if at all?** \_\_\_\_\_

15. **Describe your longest period of complete relief** \_\_\_\_\_  
 \_\_\_\_\_

16. **Does anything occur or do you notice anything else when the pain is severe?**  
 EXAMPLES: visual disturbances, nausea, perspiration, dizziness, tight chest, earache

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

17. **Since the onset of your problem, has your participation in the following activities decrease? If so, estimate percentage of pain interference in:**

		Description
Physical exercise	_____ %	_____
Leisure/social	_____ %	_____
Sleeping	_____ %	_____
Relationships	_____ %	_____
Housework & chores	_____ %	_____
Eating normal foods	_____ %	_____
Talking	_____ %	_____

18. **What other treatment have you had for your chief complaints and who was or is the doctor or provider? Please provide short, concise answer since details may be discussed at your**

PROBLEM	TREATMENT	DOCTOR OR PROVIDER Name and Specialty

19. Which of the treatments provided relief?

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20. What do you think is the cause of your pain?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. What other painful or significant medical or dental condition have you been treated for in the past two years (other than your present problem)?

EXAMPLES: arthritis, ulcer, trauma, back pain, heart condition, diabetes, depression

A) \_\_\_\_\_ B) \_\_\_\_\_ C) \_\_\_\_\_  
D) \_\_\_\_\_ E) \_\_\_\_\_ F) \_\_\_\_\_

22. List your most recent hospitalizations or surgeries (of any type):

DATE	REASON	TREATMENT

23. Have you been or do you plan to be involved in legal action regarding your pain?

\_\_\_ YES \_\_\_ NO Explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. Please check the health care providers you have seen or consulted for your present pain condition:

- |                        |                   |                        |
|------------------------|-------------------|------------------------|
| ___ Acupuncturist      | ___ ENT Physician | ___ Neurosurgeon       |
| ___ Psychologist       | ___ Allergist     | ___ Endocrinologist    |
| ___ Ophthalmologist    | ___ Surgeon       | ___ Anesthesiologist   |
| ___ Family Physician   | ___ Oral Surgeon  | ___ Psychiatrist       |
| ___ Chiropractor       | ___ Gynecologist  | ___ Physical Therapist |
| ___ Rheumatologist     | ___ Dentist       | ___ Internist          |
| ___ Orthopedic surgeon | ___ Dermatologist | ___ Neurologist        |
| ___ Pain/ Rehab Center | ___ Other: _____  |                        |

25. Which provider provided best relief? \_\_\_\_\_ What treatment? \_\_\_\_\_

\_\_\_\_\_



29. What is/are the most effective pain medications(s) you have utilized?  
\_\_\_\_\_  
\_\_\_\_\_

30. How often do you exercise? \_\_\_\_\_

31. What type of exercise do you participate in? \_\_\_\_\_  
\_\_\_\_\_

32. When you use the following, how much do you take in a day?

Coffee _____ cups/day	Tobacco _____ cigarettes/day
Cola _____ glasses/day	Beer _____ 12 oz. cans/ day
Wine _____ glasses/day	Liquor _____ oz./ day
Other _____	_____

33. Does your condition awaken you from or prevent sleep? \_\_\_\_\_ YES \_\_\_\_\_ NO  
*Describe* \_\_\_\_\_

Do you feel you get adequate sleep? \_\_\_\_\_ YES \_\_\_\_\_ NO How many hours/night? \_\_\_\_\_  
Do you feel rested after sleeping? \_\_\_\_\_ YES \_\_\_\_\_ NO  
Are you a restless sleeper? \_\_\_\_\_ YES \_\_\_\_\_ NO

34. Are you generally calm and relaxed, or tense and uptight? (*circle answer*)  
A. Are you feeling depressed? \_\_\_\_\_ YES \_\_\_\_\_ NO  
B. Are you feeling anxious? \_\_\_\_\_ YES \_\_\_\_\_ NO  
C. Are there major stressors in your life? \_\_\_\_\_ YES \_\_\_\_\_ NO

*If you answered yes to any of the above (A, B, C), please briefly explain:*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

35. Does an increase in stress, anxiety, or depression seem to make your pain worse? YES  
NO  
*Please explain* \_\_\_\_\_  
\_\_\_\_\_

36. Have you noticed clenching or grinding your teeth or other oral habits that increase pain?  
\_\_\_\_\_ YES \_\_\_\_\_ NO  
**When?** \_\_\_\_\_ Under stress or tension \_\_\_\_\_ while sleeping \_\_\_\_\_ Other: \_\_\_\_\_  
*Describe* \_\_\_\_\_

37. Do you feel that clenching or grinding your teeth causes or contributes to your pain?  
\_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ Sometimes

38. **Have you experienced any of the following:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> divorce                      | <input type="checkbox"/> marriage                               | <input type="checkbox"/> re-marriage                        |
| <input type="checkbox"/> relocation/moved             | <input type="checkbox"/> job change                             | <input type="checkbox"/> job dissatisfaction                |
| <input type="checkbox"/> separation from spouse       | <input type="checkbox"/> serious illness of friend or loved one | <input type="checkbox"/> Abuse: emotional, physical, sexual |
| <input type="checkbox"/> death of friend or loved one | <input type="checkbox"/> being fired                            | <input type="checkbox"/> chemical or alcohol dependency     |
| <input type="checkbox"/> problems with children       | <input type="checkbox"/> financial troubles                     | <input type="checkbox"/> other _____                        |

39. **Do you think you drank more beer, wine, or liquor in the past year because of your pain?**

YES  NO *If yes, what?* \_\_\_\_\_

40. **Have you ever been told you have a problem with alcohol or drugs?**  YES  NO

41. **Do you think you used too much of any drug in the past year because of your pain?**

YES  NO *If yes, what?* \_\_\_\_\_

42. **How would you describe your marital relationship now?**

- |  |  |
|--|--|
| <input type="checkbox"/> very satisfactory | <input type="checkbox"/> unsatisfactory      |
| <input type="checkbox"/> satisfactory      | <input type="checkbox"/> very unsatisfactory |

43. **Do you consider yourself a religious person?**  YES  NO

44. **Do you have family member(s) or close friend(s) who has or has had a pain problem?**

YES  NO *If so, what type?* \_\_\_\_\_

45. **What would you be able to do differently if you were out of pain?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

46. **What percentage of pain relief would be acceptable from treatment?** \_\_\_\_\_

47. **What do you expect from your encounter with the Facial Pain Center?** \_\_\_\_\_

48. **Have you considered what you would do in the event that your pain would not be eliminated or significantly improved?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

49. **What are you willing to do to improve?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

50. **What are you not willing to do to improve?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_