FACIAL PAIN QUESTIONNAIRE

So that we can understand your pain better and therefore help you better, please complete the attached questions. We realise that there are several pages and it may take some time to complete, but this is to make sure that we obtain as much information as possible on your pain so that we can manage it better.

Your Name: _____

Date: _____

A. YOUR PAIN HISTORY

1. Which statement best describes the **history** of your pain?

   - The pain first started as brief episodes ☐
   - The pain started as being constant ☐
   - The pain is still the same as was before ☐
   - The pain is longer or more constant than before ☐

2. Which statement best describes your **current pain**?

   - The pain is always present ☐
   - The pain is usually present ☐
   - The pain is occasionally present ☐
   - It is the same intensity ☐
   - The intensity varies ☐
   - The pain may go away for days ☐

3. Is your pain of more than 3 months duration? Yes ☐ No ☐

4. Does your pain cause you distress and/or suffering? Yes ☐ No ☐

5. Does your pain effect any of the following:

Chewing	Yes ☐	No ☐
Eating hard foods	Yes ☐	No ☐
Eating soft foods	Yes ☐	No ☐
Yawning	Yes ☐	No ☐
Swallowing	Yes ☐	No ☐
Talking	Yes ☐	No ☐
Exercising	Yes ☐	No ☐
Drinking	Yes ☐	No ☐
Smiling/laughing	Yes ☐	No ☐

   Any other activity (specify.....

6. Does your jaw get 'stuck', 'locked' or 'go out'? Yes ☐ No ☐

7. Are you aware of any noises in the jaw joint? Yes ☐ No ☐

8. Do your jaws regularly feel stiff, tight or tired? Yes ☐ No ☐

9. Is your pain worse in the morning? Yes ☐ No ☐

10. Are you aware of grinding your teeth? Yes ☐ No ☐

11. Do you have pain about the ears, temples or cheeks? Yes ☐ No ☐

12. Do you have frequent headaches/neck aches? Yes ☐ No ☐

13. Have you had a recent injury to your head/neck? Yes ☐ No ☐

14. Do you have any joint problems? Yes ☐ No ☐

15. Have you ever been aware of any changes in your bite? Yes ☐ No ☐

16. Have you been treated for jaw-joint problems before? Yes ☐ No ☐

    If yes, what treatments have been tried:

    .....

    .....

17. Does the pain sometimes cause you to panic? Yes ☐ No ☐

18. Does the pain make you feel as though you have Nothing to look forward to? Yes ☐ No ☐

19. Write down how you would describe your pain:

    .....

    .....

B. YOUR BELIEFS ABOUT YOUR PAIN

1. What do you believe caused your pain?

Accident at work	☐	After illness	☐
Accident at home	☐	Pain just began, no clear reason	☐
Car or other vehicle accident	☐	Other reason (specify.....	
After surgery	☐		

2. What statement best describes your thoughts on your pain?

I am uncertain as to whether my pain problem is due to a disease	☐
The pain is due to a disease that **has not** been identified	☐
The pain is due to a disease that **has** been identified	☐

3. Do you believe that an increase in pain is a sign that you are harming or injuring yourself further?

Yes ☐ No ☐

4. Do you believe that you avoid physical activity when in pain?

Yes ☐ No ☐

5. Who do you believe is responsible or to blame for your pain problem?

No one	☐	Doctors	☐	Employer	☐
Yourself	☐	Dentists	☐	Another person (specify).....	

6. State your satisfaction with the information given to you by health practitioners about your pain?

Inadequate information	☐
Some information	☐
Adequate information	☐

7. How would you rate your personal resources in the following areas?

Ability to recognise personal problems	Poor	Fair	Good	Very good
Ability to make decisions	Poor	Fair	Good	Very good
Ability to solve personal problems	Poor	Fair	Good	Very good
Self confidence in managing daily problems	Poor	Fair	Good	Very good
Ability to accept your pain	Poor	Fair	Good	Very good
Ability to manage your pain at home	Poor	Fair	Good	Very good
Ability to manage your pain at work	Poor	Fair	Good	Very good
Motivation to improve despite your pain	Poor	Fair	Good	Very good

C. YOUR EXPERIENCES OF PAIN MEDICATION

1. What has been your experience **in the past** when taking medication for pain?

   Medication has not been effective at all ☐
   Medication has provided little pain relief ☐
   Medication has provided moderate pain relief ☐
   Medication has provided excellent pain relief ☐
   Medication has made me worse off ☐

2. How have you taken prescribed medication **in the past**?

   Have always taken medication exactly as prescribed ☐
   Usually taken as prescribed ☐
   Not often taken as prescribed ☐

3. Do you get side effects from medication?

   Often ☐
   Sometimes ☐
   Rarely ☐
   Never ☐

4. What statement describes your **future expectations** in taking medication for pain?

   Impossible to improve with medication ☐
   Unlikely improvement ☐
   Uncertain improvement ☐
   Likely improvement ☐
   Certain improvement ☐

5. How likely are you to take future medication if prescribed for pain relief?

   Unlikely ☐
   Moderately likely ☐
   Very likely ☐

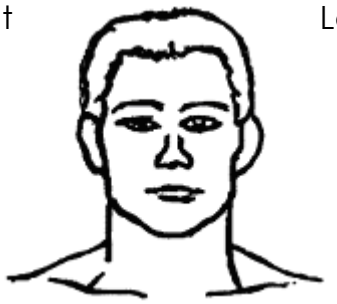
6. Please list the medications that you currently use for your pain:

Name	Dosage	When Started	Effect On Pain	Side Effects

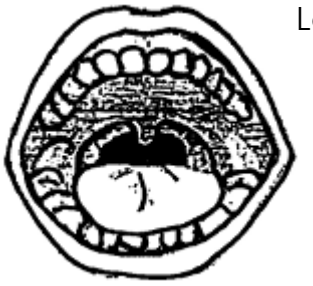
D. LOCATION OF PAIN

Please indicate where you feel pain on the diagrams below either by putting a circle around the area or a cross over a particular spot:

Right Left



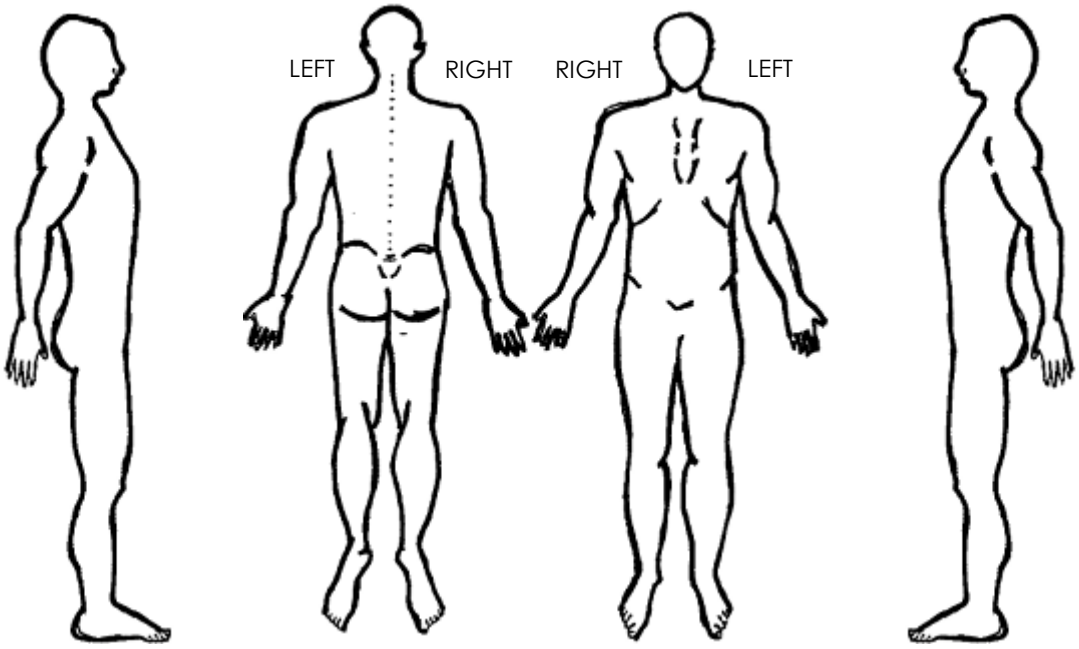
Right Left



Left

Right

RIGHT SIDE BACK FRONT LEFT SIDE



E. BRIEF PAIN INVENTORY

1. Rate your pain by circling the one number that best describes your pain at its **worst** in the past week:

   0 1 2 3 4 5 6 7 8 9 10
   No pain pain as bad as you can imagine

2. Rate your pain by circling the one number that best describes your pain at its **least** in the past week:

   0 1 2 3 4 5 6 7 8 9 10
   No pain pain as bad as you can imagine

3. Rate your pain by circling the one number that best describes your pain on **average**:

   0 1 2 3 4 5 6 7 8 9 10
   No pain pain as bad as you can imagine

4. Rate your pain by circling the one number that tells how much pain you have **now**:

   0 1 2 3 4 5 6 7 8 9 10
   No pain pain as bad as you can imagine

5. Circle the one number that describes how during the past week, **pain has interfered** with:

   General activity

   0 1 2 3 4 5 6 7 8 9 10
   does not interfere completely interferes

   Mood

   0 1 2 3 4 5 6 7 8 9 10
   does not interfere completely interferes

   Normal work

   0 1 2 3 4 5 6 7 8 9 10
   does not interfere completely interferes

   Relationship with other people

   0 1 2 3 4 5 6 7 8 9 10
   does not interfere completely interferes

   Sleep

   0 1 2 3 4 5 6 7 8 9 10
   does not interfere completely interferes

   Enjoyment of life

   0 1 2 3 4 5 6 7 8 9 10
   does not interfere completely interferes

F. HOSPITAL ANXIETY AND DEPRESSION SCALE

Doctors are aware that emotions play an important part in most illnesses and this page is designed to help your doctor know how you feel. Read each item and place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought-out response.

Tick only one box in each section

I feel tense or wound up:
- Most of the time
- A lot of the time
- Time to time, occasionally
- Not at all

I still enjoy the things I used to enjoy:
- Definitely as much
- Not quite as much
- Only a little
- Hardly at all

I get sort of frightened feeling as if something awful is about to happen:
- Very definitely and quite badly
- Yes, but not too badly
- A little, but it doesn't worry me
- Not at all

I can laugh and see the funny side of things:
- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

Worrying thoughts go through my mind:
- A great deal of time
- A lot of the time
- From time to time but not too often
- Only occasionally

I feel cheerful:
- Not at all
- Not often
- Sometimes
- Most of the time

I can sit at ease and feel relaxed:
- Definitely
- Usually
- Not often
- Not at all

I feel as if I am slowed down:
- Nearly all the time
- Very often
- Sometimes
- Not at all

I get sort of frightened feeling like butterflies in the stomach:
- Not at all
- Occasionally
- Quite often
- Very often

I have lost interest in my appearance:
- Definitely
- I don't take so much care as I should
- I may not take quite as much care
- I take just as much care as ever

I feel restless as if I have to be on the move:
- Very much indeed
- Quite a lot
- Not very much
- Not at all

I look forward with enjoyment to things:
- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

I get sudden feelings of panic:
- Very often indeed
- Quite often
- Not very often
- Not at all

I can enjoy a good book, radio, or TV programme:
- Often
- Sometimes
- Not often
- Very seldom

G. ABOUT YOURSELF

1. Age (in years): .....

2. Marital status:

Married	☐	Divorced	☐	Separated	☐
Widowed	☐	Single	☐		

3. Who do you live with:

Spouse/partner only	☐	Spouse/partner & family	☐	Relatives	☐
Alone	☐	Friends	☐	Flatmates	☐

4. What is your level of education:

University	☐	Secondary School 18 or over	☐
College	☐	Secondary School up to 16	☐

5. What was your occupation before the pain problem began: .....

6. What is your occupation now: ....

7. Current work status:

Full time	☐	Part time	☐	Casual	☐
Voluntary	☐	Home duties/housewife	☐	Student	☐
Retraining	☐	Unemployed due to pain	☐	Retired	☐

Unemployed due to other reasons (specity) .....

8. Number of hours per week working before pain began: .....

9. Number of hours per week currently able to work with the pain: .....

H. TREATMENT GOALS

Tell us about the benefits you hope for from your treatment. Read each benefit and circle its importance to you:

Goal	How important it is to you?
1. Returning or remaining at work	Very / Moderately / Slightly / Not apply
2. Reducing pain medication	Very / Moderately / Slightly / Not apply
3. Able to eat out with confidence	Very / Moderately / Slightly / Not apply
4. Feeling less self-conscious in public	Very / Moderately / Slightly / Not apply
5. Understanding my pain problem more	Very / Moderately / Slightly / Not apply
6. Reduce tendency to overdo activities	Very / Moderately / Slightly / Not apply
7. Feeling less depressed	Very / Moderately / Slightly / Not apply
8. Knowing pain is not serious	Very / Moderately / Slightly / Not apply
9. Improving my ability to socialise	Very / Moderately / Slightly / Not apply
10. Being physically intimate with partner	Very / Moderately / Slightly / Not apply
11. Meeting others with similar pain	Very / Moderately / Slightly / Not apply
12. Improving communication with doctors about pain.....	Very / Moderately / Slightly / Not apply

List below the three benefits you most hope for from your treatment. You may include items in the list above:

1. .....

2. .....

3. .....