VOR Vestibular & Orthopaedic Rehabilitation

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Please take a few moments to answer the following questions with respect to your Jaw, Face, Headache, and Neck pain. This information will assist us in gaining insight into your concerns and allow us to perform a more detailed assessment. Thank you.

1. Do you have pain or discomfort in your:
    - Jaw LEFT ___ RIGHT ___ NO ___
    - Face LEFT ___ RIGHT ___ NO ___
    - Head LEFT ___ RIGHT ___ NO ___
    - Teeth LEFT ___ RIGHT ___ NO ___
    - Ears LEFT ___ RIGHT ___ NO ___
    - Neck LEFT ___ RIGHT ___ NO ___
    - Arms LEFT ___ RIGHT ___ NO ___
2. Do you experience any of the following in your ears?
    - Ringing YES ___ NO ___
    - Dizziness/Vertigo/Balance problems YES ___ NO ___
    - Ear pain YES ___ NO ___
    - Ear fullness YES ___ NO ___
3. Do you have any pins and needles in your jaw/face/head? YES ___ NO ___
4. Do you have any areas of numbness in your jaw/face/head? YES ___ NO ___
5. Do you have any other unusual feelings or sensations? YES ___ NO ___
6. Do all of the pains come on at the same time? YES ___ NO ___
7. Is your pain constant? YES ___ NO ___
8. Over the past few days, has the pain be getting: BETTER ___ WORSE ___ SAME ___
9. Do any of the following cause pain or discomfort?
    - Opening the mouth YES ___ NO ___
    - Closing the mouth YES ___ NO ___
    - Eating/Chewing YES ___ NO ___
    - Yawning YES ___ NO ___
    - Swallowing YES ___ NO ___
    - Speaking YES ___ NO ___
    - Shouting/Singing YES ___ NO ___
    - Talking on the Telephone YES ___ NO ___
10. Does your bite feel uncomfortable or unusual? YES ___ NO ___
11. Do you grind your teeth? YES ___ NO ___
12. Do you hold your teeth closely together? YES ___ NO ___
13. Does your jaw click? YES ___ NO ___
14. Do you hear noises in your jaw joint? YES ___ NO ___

15. Does your jaw ever:
    - Get stuck? YES ___ NO ___
    - Lock? YES ___ NO ___
    - Go out? YES ___ NO ___
16. Does jaw pain wake you at night? YES ___ NO ___
17. Does the pain feel better after a night's rest? YES ___ NO ___
18. Do you have joint stiffness in the morning? YES ___ NO ___
19. Does the pain vary throughout the day? YES ___ NO ___
20. Does the pain increase steadily as the day goes on? YES ___ NO ___
21. Does the pain depend on the activity you are doing? YES ___ NO ___
22. Do you have difficulty chewing hard foods? YES ___ NO ___
23. Do you prefer to chew food on one side versus the other? If yes, LEFT ___ RIGHT ___
    - Does chewing food on the <u>opposite</u> side increase your pain? YES ___ NO ___
24. Have you ever had any injury to your:
    - Jaw YES ___ NO ___
    - Head YES ___ NO ___
    - Neck YES ___ NO ___
25. Have you been involved in a motor vehicle accident with injuries? YES ___ NO ___
26. Do you do any of the following?
    - Chew gum YES ___ NO ___
    - Bite your nails/pen YES ___ NO ___
    - Chew your hair YES ___ NO ___
    - Rest your chin on your hand YES ___ NO ___
    - Smoke YES ___ NO ___
    - Breathe mostly through your mouth YES ___ NO ___
27. Have you recently been seen by any of the following for your problem?
    - Dentist YES ___ NO ___
    - Periodontist/Orthodontist/Endodontist YES ___ NO ___
    - Other Physiotherapist YES ___ NO ___
    - Chiropractor YES ___ NO ___
    - Massage therapist YES ___ NO ___
28. Do you use a night guard or dental appliance? YES ___ NO ___
    - Please describe:

      ____

      ____

29. Have you had any X-rays, CT scans, MRIs of the head/jaw/neck?

    ____

    ____

30. Please tell us about your dental history (previous surgeries, tooth extractions, root canals, ect.)
    - Please describe (length, type, purpose):

      ____

      ____

      ____

31. Do you suffer from headaches? YES ___ NO ___
    - How often? (circle) DAILY WEEKLY MONTHLY PERIODICALLY
32. Do you suffer from migraines? YES ___ NO ___
    - What are your triggers? ____
    - How long do your migraines last? ____
33. On the diagrams below could you indicate where your headaches typically occur. Use "X" for sharp/stabbing, '//' for dull ache, "P" for pressure, "T" for tenderness.

FRONT	RIGHT	LEFT	BACK