MAURICE R GROWNEY, JR., D.D.S.
OROFACIAL PAIN

NAME:_____DATE:_____

Please list your problems from the last week below. Write the worst problem FIRST, and the LEAST bothersome problem last.

1. _____
2. _____
3. _____

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*****TYPICAL SYMPTOMS OVER THE LAST WEEK*****

Please rate each of your symptoms below as they have TYPICALLY been during the past week
Please rate the SEVERITY of your pain according to the scale:
Make sure to ***circle*** all appropriate numbers

no pain 0 1 2 3 4 5 6 7 8 9 10 your worst pain

SYMPTOM	< SCALE TO USE >										
1. HEADACHE SEVERITY:	0	1	2	3	4	5	6	7	8	9	10
How long does it last?	1.Secs		2.Mins		3.Hours		4.Days		5.Constant		
How often last week?	1.Secs		2.Mins		3.Hours		4.Days		5.Constant		
2. TOOTH PAIN SEVERITY:	0	1	2	3	4	5	6	7	8	9	10
How long does it last?	1.Secs		2.Mins		3.Hours		4.Days		5.Constant		
How often last week?	1.Secs		2.Mins		3.Hours		4.Days		5.Constant		
3. NECK PAIN SEVERITY:	0	1	2	3	4	5	6	7	8	9	10
How long does it last?	1.Secs		2.Mins		3.Hours		4.Days		5.Constant		
How often last week?	1.Secs		2.Mins		3.Hours		4.Days		5.Constant		
4. FACE PAIN SEVERITY:	0	1	2	3	4	5	6	7	8	9	10
How long does it last?	1.Secs		2.Mins		3.Hours		4.Days		5.Constant		
How often last week?	1.Secs		2.Mins		3.Hours		4.Days		5.Constant		
5. JOINT PAIN SEVERITY:	0	1	2	3	4	5	6	7	8	9	10
How long does it last?	1.Secs		2.Mins		3.Hours		4.Days		5.Constant		
How often last week?	1.Secs		2.Mins		3.Hours		4.Days		5.Constant		
6. PAIN WHEN MOVING JAW SEVERITY:	0	1	2	3	4	5	6	7	8	9	10
7. DIFFICULT TO EAT, OPEN	1.None		2.Some		3.Quite a bit		4.A great deal				
8. NOISES IN JAW	1.None		2.Some		3.Quite a bit		4.A great deal				
9. DIFFICULTY SLEEPING	1.None		2.Some		3.Quite a bit		4.A great deal				
10. How well do you understand your problem?	1.None		2.Some		3.Quite a bit		4.A great deal				

Complete the opposite side please

SYMPTOMS

Specific Areas of Pain

Please mark the area(s) where you experience pain on the diagrams below