BRENTWOOD CHIROPRACTIC CLINIC

Move Better. Feel Better. Live Better.

JAW DYSFUNCTION QUESTIONNAIRE

Because of your jaw pain, please indicate how your life has been affected. Circle the number that best describes how your jaw pain has interfered *today,* with the following:

A. Mood:

0 1 2 3 4 5 6 7

No interference — Complete interference

B. Sleep:

0 1 2 3 4 5 6 7

No interference — Complete interference

C. Normal work (includes work outside the home and household chores):

0 1 2 3 4 5 6 7

No interference — Complete interference

D. Usual recreational activities (sports, hobbies, gym):

0 1 2 3 4 5 6 7

No interference — Complete interference

E. Carrying on a conversation:

0 1 2 3 4 5 6 7

No interference — Complete interference

F. Eating hard or chewy foods (steak, bagels, carrots, nuts, apples):

0 1 2 3 4 5 6 7

No interference — Complete interference

G. Eating soft foods (mashed potatoes, yogurt, scrambled eggs, porridge):

0 1 2 3 4 5 6 7

No interference — Complete interference

H. Drinking liquids:

0 1 2 3 4 5 6 7

No interference — Complete interference

I. Yawning/Opening wide:

0 1 2 3 4 5 6 7

No interference — Complete interference

J. Please indicate your level of jaw pain today:

0 1 2 3 4 5 6 7

No pain — Severe pain

Name:_____ Signature:_____ Date:_____ Score:____

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