

Questionnaire about functional disorders

First name:	Patientnumber: Date: Practice Stamp:
PRE-TREATMENT AND CURR	RENT HEALTH ISSUES
With which symptoms are you visiting us?	
	ntal) medical treatment because of these symptoms? yes O no O orresponding symptoms and the respective treatment:
Period of time:	Doctor:
(Accompanying) Symptoms:	
Treatment:	
Period of time:	Doctor:
(Accompanying) Symptoms: _	
Treatment:	
PRE-HISTORY	

Please tick the descriptions below that apply to your current symptoms.

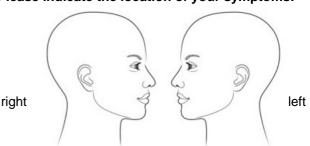
Pain:

- O Toothache
- O Headache
- O Neck tension
- O Pain in the temporal region (between eyes and ears)
- O Ear pain / dizziness / tinnitus
- O Pain when opening the mouth
- O Pain when biting / chewing
- O Frequent pain in other places

Physical complaints:

- O Complaints occur at certain times of the day
- O Complaints have changed lately
- O Complaints do stop to occur on vacation
- O Complaints affect my performance
- O It was preceded by an accident or similar in the shoulder or head area
- O There are complaints in the spine or in other joints
- O I was or am in medical treatment because of the complaints Medical specialty:
 - O General O Orthopedics O Neurology O Other
 - O I was or am in dental treatment because of this pain

Please indicate the location of your symptoms:



Further observations:

- O The teeth "do not fit together properly"
- O When chewing, I only use one side
- O When chewing, the joints crack / crunch
- O The mouth can only be opened to a limited extent
- O I had a difficult wisdom teeth extraction
- O I grind or press my teeth
- O Individual teeth are often very sensitive to temperature
- O Dry mouth or (tongue-) burning sensations are common
- O A feeling of numbness often occurs in the nose and lip area
- O Do you know what your sleeping position is usually like?
 - O left O right O back O stomach