



Headache / Tooth Grinding Questionnaire

Please complete this questionnaire and give it to your dentist.

	yes	no
<i>Do you clench or grind your teeth during the day?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Have you been aware of clenching or grinding your teeth at night?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Are your jaws or teeth tired when you awaken?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Do you suffer from chronic headaches of any kind?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Do you experience chronic neck or shoulder pain?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Have you ever had pain in your jaw joints, the sides of your face or around your ear?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Have your jaws ever clicked or popped when you open your mouth?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Have you ever experienced difficulty moving your jaw or opening your mouth wide?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Do you chew on only one side of your mouth?</i>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Do you wear or have you ever worn a bite splint?</i>	<input type="checkbox"/>	<input type="checkbox"/>

Signature:

Date:

MICHAEL MOONEY
BDS (Sheff) LDS RCS (Eng)

IAN BLAIR
BDS (Edin) DPDS (Bristol)

SHELLEY McFARLANE
BDS (QUB)

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