



## 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  
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