“Problems with the bite” questionnaire:

In order for us to understand your problems and concerns could you please complete the attached questionnaire?

We understand that this is an extensive questionnaire but each question is there for a specific purpose to help to manage your issues to the best of our abilities.

Your Name: ______________________________

Date: ______________________________

A. YOUR HISTORY,PLEASE

HOW DOES THIS PROBLEM AFFECT YOU NOW?

1. Do your problems affect any of the following:

Chewing	Yes ☐	No ☐
Eating hard foods	Yes ☐	No ☐
Eating soft foods	Yes ☐	No ☐
Yawning	Yes ☐	No ☐
Swallowing	Yes ☐	No ☐
Talking	Yes ☐	No ☐
Exercising	Yes ☐	No ☐
Drinking	Yes ☐	No ☐
Smiling/laughing	Yes ☐	No ☐
Sleep	Yes ☐	No ☐
Vision	Yes ☐	No ☐

Any other activity (please specify) ....

2. How long have you had problems with your bite or occlusion?
   - 0-6 months ☐
   - 7-12 months ☐
   - 13-18 months ☐
   - 19-24 months ☐
   - 2 – 5 years ☐
   - Over 5 years ☐

3. Do your problems cause you distress and/or suffering? Yes ☐ No ☐

4. Are your problems worse in the morning? Yes ☐ No ☐

5. Are you aware of grinding or clenching your teeth? Yes ☐ No ☐

6. Do you have pain about the ears, temples or cheeks? Yes ☐ No ☐

7. Do you have frequent headaches/neck/shoulder aches? Yes ☐ No ☐

8. Have you had a recent injury to your head/neck? Yes ☐ No ☐

9. Are you having / have you received treatment **from anyone** regarding any neck/shoulder/ other problems Yes ☐ No ☐

10. Do you have any joint problems? Yes ☐ No ☐

11. Have you been treated for your jaw-joint or bite problems before? Yes ☐ No ☐

    If yes, what treatments have been tried?

    Who has tried them?

    How often have you seen **anyone** about this problem?

    ....

    ....

    ....

    ....

12. Have you ever had an **MRI scan or Cone beam CT scan** of your jaw joints?

Yes ☐ No ☐

If yes, how many scans have you had?

- 1 ☐
- 2 ☐
- 3 ☐

More than 3 ☐

13. Have you been aware of any recent changes in your bite? Yes ☐ No ☐

14. How many dentists have you seen in the past to correct your bite or occlusion?
    - 1-2 ☐
    - 3-4 ☐
    - 5 or more ☐

15. Have you ever seen a Restorative Consultant or Prosthodontic specialist about your bite?

    Yes ☐ No ☐

    If yes, how many?
    - 1-2 ☐
    - 3-4 ☐
    - 5 or more ☐

16. Have you ever seen an orthodontist about correcting your bite? Yes ☐ No ☐

17. Have you, or you have had, a mouth guard (splint)? Yes ☐..................... No ☐

    If yes, do you wear your mouth guard/splint regularly? Yes ☐ No ☐

18. Does your bite sometimes cause you to panic? Yes ☐ No ☐

19. Do the problems with your bite make you feel as though you have nothing to look forward to? Yes ☐ No ☐

20. Who has attended today's appointment with you?

21. Please describe your main problems :

....

....

....

....

B. YOUR BELIEFS ABOUT YOUR PROBLEMS

C. What do you believe caused your initial **bite problems**?

a. A dental filling ☐
b. Dental extraction ☐
c. New crown ☐
d. New veneer ☐
e. Other cause ☐

2. What statement best describes your thoughts on your bite?

I am uncertain as to whether my bite problem is due to a disease ☐

The problem is due to a disease that **has not** been identified ☐

The problem is due to a disease that **has** been identified ☐

3. Who do you believe is responsible or to blame for your bite problem?

No one ☐ Dentists ☐ Yourself ☐

Another person (specify) ☐ Other ☐

4. Do you feel that correcting the problems with your bite will: (tick as many as you like)

a. Allow you to be happy ☐
b. Make you feel like you did before the problem ☐
c. Resolve your on -going neck/shoulder/posture problems ☐
d. Improve your quality of life ☐

6.How would you rate your personal resources in the following areas?

Ability to recognise personal problems	Poor	Fair	Good	Very good
Ability to make decisions	Poor	Fair	Good	Very good
Ability to solve personal problems	Poor	Fair	Good	Very good
Self confidence in managing daily problems	Poor	Fair	Good	Very good
Ability to accept your bite	Poor	Fair	Good	Very good
Ability to manage your bite problems at home	Poor	Fair	Good	Very good
Ability to manage your bite problems at work	Poor	Fair	Good	Very good
Motivation to improve despite your bite issues	Poor	Fair	Good	Very good

---

5. What do you think would solve your problems?

C. YOUR EXPERIENCES OF PAIN MEDICATION

1. What has been your experience **in the past** when taking medication?

   Medication has not been effective at all ☐

   Medication has provided little pain relief ☐

   Medication has provided moderate pain relief ☐

   Medication has provided excellent pain relief ☐

   Medication has made me worse off ☐

2. How have you taken prescribed medication **in the past**?

   Have always taken medication exactly as prescribed ☐

   Usually taken as prescribed ☐

   Not often taken as prescribed ☐

3. Do you get side effects from medication?

   Often ☐

   Sometimes ☐

   Rarely ☐

   Never ☐

4. What statement describes your **future expectations** in taking medication for pain?

   Impossible to improve with medication ☐

   Unlikely improvement ☐

   Uncertain improvement ☐

   Likely improvement ☐

   Certain improvement ☐

5. How likely are you to take future medication if it is prescribed for your problems?

   Unlikely ☐

   Moderately likely ☐

   Very likely ☐

Do you have any visual problems? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

If yes, how many a day: _______

For how many years: _______

Do you consume alcohol? Yes ☐ No ☐

If yes, how many units a week? ______________________

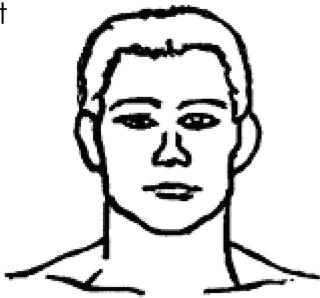
6. Please list the medications that you currently use:

Name	Dosage	When Started	Effect On Pain	Side Effects

D. LOCATION OF PROBLEMS

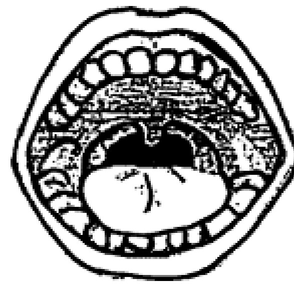
Please indicate where you feel you have an issue on the diagrams below either by putting a circle around the area or a cross over that particular spot:

Right



Left

Right

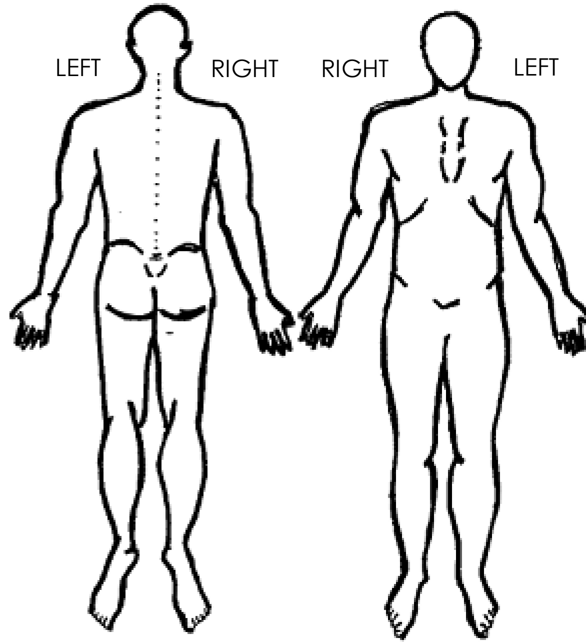


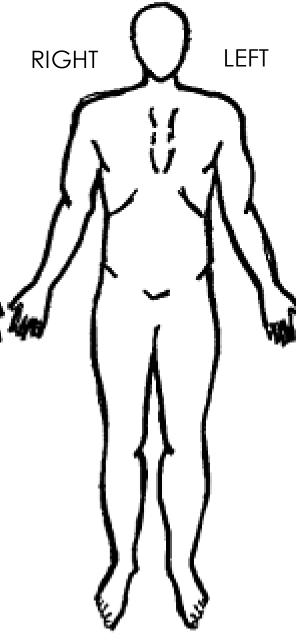
Left

Left

Right

RIGHT SIDE


BACK
LEFT
RIGHT


FRONT
RIGHT
LEFT

LEFT SIDE

E. THE SCALE OF YOUR ISSUES OR PROBLEMS

1. Rate your pain by circling the one number that best describes your problem at its **worst** in the past week:

   0 1 2 3 4 5 6 7 8 9 10

   0=No problem 10=Problem as bad as you can imagine

2. Rate your pain by circling the one number that best describes your problem at its **least** in the past week:

   0 1 2 3 4 5 6 7 8 9 10

   0=No problem 10=Problem as bad as you can imagine

3. Rate your pain by circling the one number that best describes your issues on **average**:

   0 1 2 3 4 5 6 7 8 9 10

   0=No problem 10=Problem as bad as you can imagine

4. Rate your pain by circling the one number that tells how much of a problem you have **now**:

   0 1 2 3 4 5 6 7 8 9 10

5. Circle the one number that describes how during the past week, the problem **has interfered** with:

   General activity

   0 1 2 3 4 5 6 7 8 9 10

   0=Does not interfere 10=completely interferes

   Mood

   0 1 2 3 4 5 6 7 8 9 10

   0=Does not interfere 10=completely interferes

Normal work

0 1 2 3 4 5 6 7 8 9 10

0=Does not interfere 10=completely interferes

Relationship with other people

0 1 2 3 4 5 6 7 8 9 10

0=Does not interfere 10=completely interferes

Sleep

0 1 2 3 4 5 6 7 8 9 10

Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

F. HOSPITAL ANXIETY AND DEPRESSION SCALE (CONFIDENTIAL)

Many people are aware that emotions play an important part in illnesses and this page is designed to help your clinician to know **how you feel.** Please read each item and place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week. Please don't take too long over your replies. Your quick reaction to each item will probably be more accurate than a long thought-out response.

Please tick only one box in each section

I feel tense or wound up:

Most of the time ....
A lot of the time...
Time to time, occasionally........................
Not at all...

I can laugh and see the funny side of things:

As much as I always could ....
Not quite so much now............................
Definitely not so much now......................
Not at all ....

I still enjoy the things I used to enjoy:

Definitely as much ....
Not quite as much ....
Only a little ....
Hardly at all..

Worrying thoughts go through my mind:

A great deal of time ....
A lot of the time...
From time to time but not too often ....
Only occasionally......................................

I get sort of frightened feeling as if something awful is about to happen:

Very definitely and quite badly................
Yes, but not too badly...............................
A little, but it doesn't worry me.................
Not at all...

I feel cheerful:

Not at all ....
Not often ....
Sometimes..
Most of the time ....

I can sit at ease and feel relaxed:

Definitely ....

Usually ....

Not often ....

Not at all ....

I feel as if I am slowed down:

Nearly all the time ....

Very often ....

Sometimes ....

Not at all ....

I get sort of frightened feeling like butterflies in the stomach:

Not at all ....

Occasionally ....

Quite often ....

Very often ....

I have lost interest in my appearance:

Definitely ....

I don't take so much care as I should .....

I may not take quite as much care ....

I take just as much care as ever ....

I feel restless as if I have to be on the move:

Very much indeed ....

Quite a lot ....

Not very much ....

Not at all ....

I look forward with enjoyment to things:

As much as I ever did ....

Rather less than I used to ....

Definitely less than I used to ....

Hardly at all ....

I get sudden feelings of panic:

Very often indeed ....

Quite often ....

Not very often ....

Not at all ....

I can enjoy a good book, radio, or TV programme:

Often ....

Sometimes ....

Not often ....

Very seldom ....

G. ABOUT YOURSELF

1. Age (in years): ....

2. Marital status:
   Married ☐ Divorced ☐ Separated ☐

   Widowed ☐

   Single ☐

3. Who do you live with:

   Spouse/partner only ☐ Spouse/partner & family ☐ Relatives ☐

   Alone ☐

   Friends ☐

   Flatmates ☐

   Family ☐

4. What is your level of education:

   University ☐ Secondary School 18 or over ☐

   College ☐

   Secondary School up to 16 ☐

5. What was your occupation before the pain problem began: ....

6. What is your occupation now: ....

7. Current work status:

Full time ☐ Part time ☐ Casual ☐ ....

Voluntary duties/housewife☐ ☐ ☐

Retraining ☐ Unemployed due to pain ☐ Retired

Unemployed due to pain ☐

Unemployed due to other reasons (specify) ……………………………

8. Number of hours per week working before pain began: ....

9. Number of hours per week currently able to work with the pain: ....

H. TREATMENT GOALS

Tell us about the benefits you hope for from your treatment. Read each benefit and circle its importance to you:

Goals	How important it is to you?
1. Returning or remaining at work	Very / Moderately / Slightly / Not apply
2. Reducing medication	Very / Moderately / Slightly / Not apply
3. Able to eat out with confidence	Very / Moderately / Slightly / Not apply
4. Feeling less self-conscious in public	Very / Moderately / Slightly / Not apply
5. Understanding my problem more	Very / Moderately / Slightly / Not apply
6. Reduce tendency to overdo activities	Very / Moderately / Slightly / Not apply
7. Feeling less depressed	Very / Moderately / Slightly / Not apply
8. Knowing pain is not serious	Very / Moderately / Slightly / Not apply
9. Improving my ability to socialise	Very / Moderately / Slightly / Not apply
10. Being physically intimate with partner	Very / Moderately / Slightly / Not apply
11. Meeting others with similar pain	Very / Moderately / Slightly / Not apply

12. Improving communication with clinicians about your problems
    Very / Moderately / Slightly / Not apply

List below the three benefits you most hope for from your treatment. You may include items not in in the list above:

1. ....

2. ....

3. ....

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE