The Oral Behavior Checklist

How often do you do each of the following activities, based on **the last month**? If the frequency of the activity varies, choose the higher option. Please place a (√) response for each item and do not skip any items.

	Activities During Sleep	**None of the time**	**< 1 Night /Month**	**1-3 Nights /Month**	**1-3 Nights /Week**	**4-7 Nights/ Week**
1	Clench or grind teeth **when asleep**, based on any information you may have	☐	☐	☐	☐	☐
2	Sleep in a position that puts pressure on the jaw (for example, on stomach, on the side)	☐	☐	☐	☐	☐
	Activities During Waking Hours	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
3	Grind teeth together **during waking hours**	☐	☐	☐	☐	☐
4	Clench teeth together **during waking hours**	☐	☐	☐	☐	☐
5	Press, touch, or hold teeth together other than while eating (that is, contact between upper and lower teeth)	☐	☐	☐	☐	☐
6	Hold, tighten, or tense muscles without clenching or bringing teeth together	☐	☐	☐	☐	☐
7	Hold or jut jaw forward or to the side	☐	☐	☐	☐	☐
8	Press tongue forcibly against teeth	☐	☐	☐	☐	☐
9	Place tongue between teeth	☐	☐	☐	☐	☐
10	Bite, chew, or play with your tongue, cheeks or lips	☐	☐	☐	☐	☐
11	Hold jaw in rigid or tense position, such as to brace or protect the jaw	☐	☐	☐	☐	☐
12	Hold between the teeth or bite objects such as hair, pipe, pencil, pens, fingers, fingernails, etc	☐	☐	☐	☐	☐
13	Use chewing gum	☐	☐	☐	☐	☐
14	Play musical instrument that involves use of mouth or jaw (for example, woodwind, brass, string instruments)	☐	☐	☐	☐	☐
15	Lean with your hand on the jaw, such as cupping or resting the chin in the hand	☐	☐	☐	☐	☐
16	Chew food on one side only	☐	☐	☐	☐	☐
17	Eating between meals (that is, food that requires chewing)	☐	☐	☐	☐	☐
18	Sustained talking (for example, teaching, sales, customer service)	☐	☐	☐	☐	☐
19	Singing	☐	☐	☐	☐	☐
20	Yawning	☐	☐	☐	☐	☐
21	Hold telephone between your head and shoulders	☐	☐	☐	☐	☐

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Patient Health Questionnaire-15: Physical Symptoms

During the last 4 weeks, how much have you have been bothered by any of the following problems? Please place a check mark in the box to indicate your answer.

		Not bothered 0	Bothered a little 1	Bothered a lot 2
1.	Stomach pain	☐	☐	☐
2.	Back pain	☐	☐	☐
3.	Pain in your arms, legs, or joints (knees, hips, etc)	☐	☐	☐
4.	Menstrual cramps or other problems with your periods [women only]	☐	☐	☐
5.	Headaches	☐	☐	☐
6.	Chest pain	☐	☐	☐
7.	Dizziness	☐	☐	☐
8.	Fainting spells	☐	☐	☐
9.	Feeling your heart pound or race	☐	☐	☐
10.	Shortness of breath	☐	☐	☐
11.	Pain or problems during sexual intercourse	☐	☐	☐
12.	Constipation, loose bowels, or diarrhea	☐	☐	☐
13.	Nausea, gas, or indigestion	☐	☐	☐
14.	Feeling tired or having low energy	☐	☐	☐
15.	Trouble sleeping	☐	☐	☐

TOTAL SCORE =

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Graded Chronic Pain Scale Version 2.0

1. On how many days in the **last 6 months** have you had facial pain? _______ Days

2. How would you rate your facial pain **RIGHT NOW?** Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be".

No pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

3. In the LAST 30 DAYS, how would you rate your **WORST** facial pain? Use the same scale, where 0 is "no pain" and 10 is "pain as bad as could be".

No pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

4. In the LAST 30 DAYS, **ON AVERAGE**, how would you rate your facial pain? Use the same scale, where 0 is "no pain" and 10 is "pain as bad as could be". [That is, *your usual pain* at times you were in pain.]

No pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

5. In the LAST 30 DAYS, how many days did your facial pain keep you from doing your **USUAL ACTIVITIES** like work, school, or housework? (every day = 30 days)

_______ Days

6. In the LAST 30 DAYS, how much has facial pain interfered with your **DAILY ACTIVITIES**? Use a 0-10 scale, where 0 is “no interference: and 10 is “unable to carry on any activities”.

No interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10

7. In the LAST 30 DAYS, how much has facial pain interfered with your **RECREATIONAL, SOCIAL AND FAMILY ACTIVITIES**? Use the same scale, where 0 is “no interference: and 10 is “unable to carry on any activities”.

No interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10

8. In the LAST 30 DAYS, how much has facial pain interfered with your **ABILITY TO WORK**, including housework? Use the same scale, where 0 is “no interference: and 10 is “unable to carry on any activities”.

No interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10

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TMD-PAIN SCREENER

1. In the last 30 days, how long did any pain last in your jaw or temple area on either side?
   a. No pain
   b. Pain comes and goes
   c. Pain is always present

2. In the last 30 days, have you had pain or stiffness in your jaw on awakening?
   a. No
   b. Yes

3. In the last 30 days, did the following activities change any pain (that is, make it better or make it worse) in your jaw or temple area on either side?

   A. Chewing hard or tough food
      a. No
      b. Yes

   B. Opening your mouth or moving your jaw forward or to the side
      a. No
      b. Yes

   C. Jaw habits such as holding teeth together, clenching, grinding, or chewing gum
      a. No
      b. Yes

   D. Other jaw activities such as talking, kissing, or yawning
      a. No
      b. Yes

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Patient Health Questionnaire - 4

Over the last 2 weeks, how often have you been bothered by the following problems? Please place a check mark in the box to indicate your answer.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Little interest or pleasure in doing things	☐	☐	☐	☐
4. Feeling down, depressed, or hopeless	☐	☐	☐	☐

TOTAL SCORE =

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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