Q1. How often have you performed each of the following oral behaviors in the last month?

	Activities During Sleep	None of the Time	<1 night / month	1-3 nights / month	1-3 Nights / week	4-7 N ights / week
1.1	Clench or grind your teeth while you're asleep					
1.2	Sleep in a position that puts pressure on the jaw					

	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
1.3	Grind teeth together					
1.4	Clench teeth together					
1.5	Contact between upper and lower teeth other than while eating					
1.6	Tighten or tense muscles without teeth contact					
1.7	Keep the lower the jaw forward or laterally					
1.8	Push the tongue firmly against your teeth					
1.9	Place the tongue between the teeth					
1.10	Bite, chew or play with your tongue, cheeks or lips					
1.11	Keep the jaw in a rigid or tense position, such as supporting or protecting it					
1.12	Keep objects such as hair pin, pipe, pencil, pens, fingers, nails, etc. between your teeth					
1.13	Chewing gum					
1.14	Play musical instruments that require the use of the mouth or jaw (such as woodwind instruments, brass instruments, stringed instruments)					
1.15	Place your hand on the jaw in the rest position, such as placing the chin in the hand cord					
1.16	Chew your food on one side only					
1.17	Eat between main meals (only foods that require chewing)					
1.18	Speaking for a long time (eg teacher, merchant, customer service)					
1.19	Sing					
1.20	Yawn					
1.21	Hold the phone between your head and shoulders					

Q2. Indicate in the following questions the extent of pain on a scale from 0 to 10 where 0 = "Absence of pain", and 10= "Unsustainable pain".

0 = Absence of Pain **5 = Moderate Pain** **10 = Severe Pain**

2.1	How would you rate your facial pain **right now**?	
2.2	In the past 3 months how do you rate your **worst** facial pain?	
2.3	In the past 3 months, **on average**, how do you rate your facial pain?	
2.4	In the last 3 months, how many days did your facial pain keep you from doing your **usual activities** (work, study, housework)? (Specify number of days)	
2.5	In the last 3 months, how much has your facial pain interfered in your **daily activities**? (On a sclae from 0-10 where 0 = no interference / 10 = inability to perform any activity)	
2.6	In the last 3 months how much has your facial pain interfered with your **recreational, social and family activities?** (On a sclae from 0-10 where 0 = no interference / 10 = inability to perform any activity)	
2.7	In the last 3 months how much has your facial pain interfered with your **ability to work** including housework? (On a sclae from 0-10 where 0 = no interference / 10 = inability to perform any activity)	

Q3. Circle in the following questions the extent of jaw limitation on a scale from 0 to 10 where 0 = "No Limitation", and 10= "Severe Limitation".

3.1	Chewing	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3.2	Eat hard foods	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3.3	Eat fluffy foods	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3.4	Open wide to drink from a cup	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3.5	Open wide to bite into an apple	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3.6	Open wide to bite a sandwish	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3.7	Smile/laugh	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3.8	Talking	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3.9	Yawning	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3.10	Swallowing	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3.11	Singing	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation
3.12	Having a usual facial expression (happy/angry face)	No Limitation 0 1 2 3 4 5 6 7 8 9 10 Severe Limitation

Q4. Over the last 2 weeks, how often have you been bothered by the following problems?

		Not at all	**Several days**	**More than half the days**	**Nearly everyday**
4.1	Little interest or pleasure in doing things				
4.2	Feeling down,depressed or hopeless				
4.3	Trouble falling or staying asleep; or sleeping too much				
4.4	Feeling tired or having little energy				
4.5	Poor apetite or overeating				
4.6	Feeling bad about yourself				
4.7	Trouble concentrating on things (TV,newspapaer..)				
4.8	Being hypoactive or hyperactive				
4.9	Thinking of hurting yourself				

Q5. Over the last 4 weeks, how much have you been bothered by the following problems?

		Not Bothered	**Bothered a little**	**Bothered a lot**
5.1	Stomach pain			
5.5	Back pain			
5.3	Pain in your arms,legs,or joints (knees, hips, etc.)			
5.4	Menstrual cramps or period problems (women only)			
5.5	Headaches			
5.6	Chest Pain			
5.7	Dizziness			
5.8	Fainting			
5.9	Feeling your heart pound or race			
5.10	Shortness of breath			
5.11	Constipation, loose bowels or diarrhea			
5.12	Nausea, gas or indigestion			
5.13	Feeling tired or having low energy			
5.14	Trouble sleeping			