QUESTIONNAIRE FOR TMJ PROBLEMS

1. Do you have: Headaches?____ Stuffiness?____ Neck pain?____

   Pain in: Jaw?____ Ear?____ Face?____ Eye?____ Other?____

   If yes, which side is affected?: Right____ Left____ Both____

2. Is the pain: Dull?____ Throbbing?____ Burning?____ Stabbing?____

   Tingling?____ Other:_____

3. Is the pain: Constant?____ Frequent?____ Occasional?____

   When do you notice the pain?_____

   Is it worse in the: Morning?____ Afternoon?____ Night?____

   How long has the pain persisted?_____

4. Does it hurt to: Chew?____ Open wide?____ Close mouth?____

   Move jaw forward?____ To the right?____ To the left?____

5. Does your jaw make: A popping noise?____ Clicking?____ Grinding?____

   ____Other:_____

   Is the noise on the: Right side?____ Left side?____ Both?____

6. Has your jaw "locked" or slipped out of place? _____

   If "yes", when did this start?_____

   How often has it occurred in the last 12 months?_____

7. Do you: Grind your teeth?____ Clench?____

   If "yes", is the grinding or clenching: During the day?____ At Night?____

   24 hours?____

8. Are your teeth: Sore?____ Sensitive?____

   Do you notice that you "cannot find your bite"?_____

(Please continue to second page)

9. Do you notice any soreness in your head or neck muscles?_____

If "yes", please describe where:_____

10. Do you have problems with your: Ears?____ Hearing?____ Dizziness?____

Ringing?____

11. Is it difficult to swallow?_____ Is it painful?_____

12. Are you taking any medication?_____

If "yes", please list:_____

13. Do you have a history of any head or facial injury?_____

If "yes", please describe the injury and the date it occurred:_____

_____

14. Describe your TMJ problems in your own words:_____

_____

_____

15. Using a scale of 0 (NONE) to 10 (SEVERE), rate the following:

Intensity of the pain:_____ Effect problem has on your daily life:____

16. Is your TMJ problem getting: Worse?____ Same?____ Improving?____

17. Have you received any type of TMJ treatment?_____

If "yes", please describe:_____

Name of Dentist:_____

18. Are you receiving any physical therapy?_____

If "yes", please describe:_____

Name of Physical Therapist:_____

Patient's Name:_____ Date:_____