

TMJ PROBLEM QUESTIONNAIRE - PAGE 1

PLEASE ANSWER ALL QUESTIONS

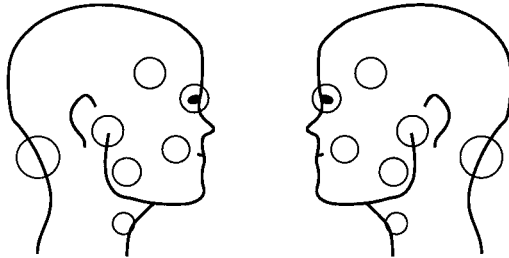
DO NOT WRITE IN THIS SPACE

I. NAME _____ AGE _____
DATE _____
REFERRED BY _____

II. DO YOU HAVE HEADACHES? _____
NECK PAIN? _____ JAW PAIN? _____
EAR PAIN? _____ FACIAL PAIN? _____
OTHER? _____

WHICH SIDE HURTS?
RIGHT _____ LEFT _____ BOTH _____

III. PLACE AN (X) IN THE CIRCLE WHERE YOU HURT.



RIGHT SIDE

LEFT SIDE

IV. HOW LONG HAVE YOU HAD THIS PAIN? _____
IS THE PAIN CONSTANT? _____

WOULD YOU DESCRIBE THE PAIN AS:
ACHING? _____ BURNING? _____ STABBING? _____
OTHER? _____

V. IS THE PAIN WORSE IN THE:
MORNING? _____ AFTERNOON? _____
AWAKE? _____ WHILE SLEEPING? _____

VI. HAVE YOU EVER INJURED OR SUSTAINED ANY FORM OF
TRAUMA OR WHIPLASH TO YOUR:
JAW? _____ HEAD? _____ NECK? _____
(IF SO, PLEASE COMPLETE THE TRAUMA QUESTIONNAIRE)

VII. WHAT MAKES THE PAIN WORSE? _____

WHAT MAKES THE PAIN BETTER? _____

WHAT MEDICATION DO YOU TAKE OR HAVE YOU PREVIOUSLY TAKEN FOR YOUR PAIN?

MEDICATION	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VIII. DOES IT HURT TO CHEW? _____ OPEN WIDE? _____
 WHICH SIDE OF JAW MAKES A POPPING NOISE? _____
 CLICKING? _____ GRINDING? _____
 OTHER NOISE? _____
 WHEN DID YOU FIRST NOTICE JAW JOINT SOUNDS? _____

IX. HAS YOUR JAW EVER LOCKED? _____
 OPEN POSITION? _____ CLOSED POSITION? _____
 WHEN DID THIS FIRST HAPPEN? _____
 LAST HAPPEN? _____

HAS YOUR JAW EVER SLIPPED OUT OF PLACE? _____
 WHICH SIDE? _____

X. HAVE YOU NOTICED A CHANGE IN YOUR BITE? _____
 FRONT TEETH? _____ BACK TEETH? _____
 HAS YOUR PROFILE CHANGED? _____

HAVE YOU NOTICED ANY CROOKEDNESS OR ASYMMETRY OF YOUR FACE OR JAW? _____ WHEN? _____

XI. ARE YOUR TEETH SORE OR SENSITIVE? _____
 DO YOU CLENCH YOUR TEETH? _____ GRIND? _____
 DURING THE DAY? _____ AT NIGHT? _____
 WHEN DID YOU START DOING THIS? _____

XII. DO YOU HAVE PROBLEMS WITH YOUR EARS? _____
 DIZZINESS? _____ RINGING? _____
 HEARING? _____ OTHER? _____

XIII. IS IT DIFFICULT TO SWALLOW? _____
 PAINFUL TO SWALLOW? _____

HAVE YOU NOTICED ANY LUMPS IN YOUR:
 FACE? _____ THROAT? _____ NECK? _____
 OTHER? _____

XIV. HAVE YOU HAD ANY PRIOR TREATMENT FOR THIS PROBLEM? _____
SPLINT? _____ WHEN? _____ DID IT HELP? _____
NIGHTGUARD? _____ WHEN? _____ DID IT HELP? _____
BITE ADJUSTMENT? _____ WHEN? _____ DID IT HELP? _____
ORTHODONTICS? _____ WHEN? _____ DID IT HELP? _____
OTHER? _____

XV. DESCRIBE THE PROBLEMS IN YOUR OWN WORDS
AS YOU UNDERSTAND THEM.

XVI. REPORTS MAY BE SENT TO MY: (NAME)
MEDICAL DOCTOR _____
DENTIST _____
OTHER _____

XVII. I HAVE COMPLETED THE ABOVE TO THE BEST OF MY
KNOWLEDGE AND I PERSONALLY HAVE FILLED IN EACH
BLANK
IN MY OWN WRITING. I CONSENT TO THE USE OF MY X-RAYS,
RECORDS, AND PHOTOS FOR SCIENTIFIC PUBLICATION OR
TEACHING PROVIDING MY NAME REMAINS ANONYMOUS.

SIGNATURE

DATE