PATIENT "TMJ" QUESTIONNAIRE

PATIENT'S FULL NAME: ______________________________ TODAY'S DATE: __________

PLEASE DESCRIBE YOUR PROBLEM (YOUR MAIN COMPLAINT, YOUR REASON FOR SEEKING TREATMENT):

____

____

____

*FOR EACH AREA LISTED BELOW, CIRCLE "L" (LEFT) OR "R" (RIGHT) FOR **ALL** AREAS THAT HAVE PAIN OR PROBLEMS:*

HEADACHE	LEFT	RIGHT
Forehead	L	R
Side of head	L	R
Back of head	L	R
Sinus headache	L	R
Migraine	L	R
NECK		
Back of neck	L	R
Side of neck	L	R
Front of neck	L	R
SHOULDERS	L	R
EARS		
Decreased hearing	L	R
Dizziness	L	R
Ringing or buzzing	L	R
Earaches	L	R
Sensitive to noise	L	R
Fluid or "stuffy"	L	R
Pain in ear canal	L	R
EYES		
Pain behind eyes	L	R
Tearing, watering	L	R
Sensitive to light	L	R
Loss of vision	L	R
Pressure	L	R
FACE		
In front of ear	L	R
Below ear	L	R
Behind ear	L	R
Above ear	L	R
Cheeks	L	R
Angle of Jaw	L	R
TMJ (JAW JOINT)		
Clicking/popping	L	R
Grinding noise	L	R
"Catches" opening	L	R
"Catches" closing	L	R
"Goes out" opening	L	R
"Goes out" closing	L	R
Upon awakening, sore/tired muscles	L	R
Upon awakening, sore/tender teeth	L	R

FOR EACH QUESTION BELOW, CIRCLE "YES" OR "NO". DO YOU HAVE ANY PROBLEMS WITH:

NASAL/SINUS AREAS?	YES	NO
Blood or pus from nostrils	Y	N
Post-nasal drip	Y	N
Runny or stuffy nose	Y	N
Allergic rhinitis	Y	N
Persistent sore throat	Y	N
Tight throat	Y	N
TOOTHACHES?	Y	N
SORE/INFLAMED/BLEEDING GUMS?	Y	N
DIZZINESS OR LIGHTHEADEDNESS?	Y	N
NECK NOISES? (grinding or clicking when moving head)	Y	N
NECK STIFFNESS? (unable to move neck comfortably)	Y	N
JAW MOVEMENT PROBLEMS?		
Limited opening	Y	N
Limited side movement	Y	N
Locks open (can't close)	Y	N
Locks closed (can't open)	Y	N
Does not move smoothly	Y	N
Clenching habit (biting or squeezing the teeth)	Y	N
Bruxing habit (grinding or gnashing the teeth)		
At night	Y	N
During the day	Y	N
UNUSUAL SENSATIONS IN THE SOFT TISSUES OF THE MOUTH (TONGUE, LIPS, CHEEKS)?		
Numbness, "dead" feeling	Y	N
Pain	Y	N
Itching, burning, tingling	Y	N
Dryness, grittiness	Y	N
Abnormal taste sensations	Y	N

OF ALL THE PROBLEMS YOU HAVE LISTED ON THIS PAGE, WHICH IS THE WORST, AND WHEN DID IT FIRST OCCUR?

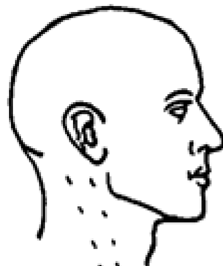
____

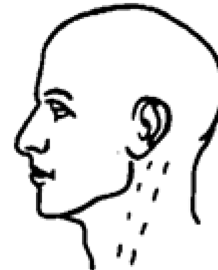
____

(PLEASE GO ON TO PAGE 2 OF THIS QUESTIONNAIRE)

PATIENT "TMJ" QUESTIONNAIRE (page 2)

ON THE SKETCH BELOW, PLEASE SHOW (AS EXACTLY AS YOU CAN) WHERE YOUR PROBLEM(S) IS/ARE (shade in darkly your area of GREATEST pain or discomfort; shade in other areas lightly)


Your Right


Your Left

ON A SCALE OF 1 TO 10, WITH 1 A VERY MILD DISCOMFORT, AND 10 BEING THE WORST PAIN IMAGINABLE, WHERE WOULD YOU RANK YOUR PAIN (CIRCLE THE APPROPRIATE NUMBER 1 TO 10)

YOUR PAIN AT ITS **WORST EVER:**	1	2	3	4	5	6	7	8	9	10
YOUR PAIN AT ITS **BEST RECENTLY:**	1	2	3	4	5	6	7	8	9	10
YOUR PAIN AT **THIS MOMENT:**	1	2	3	4	5	6	7	8	9	10

CIRCLE YES OR NO FOR EACH OF THE FOLLOWING:

Do you sleep on your back?	YES	NO
side?	YES	NO
stomach?	YES	NO
random?	YES	NO
Have you ever had an injury involving your head?	YES	NO
your mouth?	YES	NO
your jaws?	YES	NO
your neck?	YES	NO
Does your "bite" feel uncomfortable?	YES	NO
Does your "bite" ever change or feel different?	YES	NO
Do you ever have pain when chewing, yawning, opening?	YES	NO

FOR THE PAIN YOU HAVE ***NOW:***

Have you ever worn a splint, bite plane, night guard, etc.?	YES	NO
Have your teeth been ground or "equilibrated"?	YES	NO
Have teeth been crowned?	YES	NO
Have you had TMJ injections or TMJ surgery?	YES	NO
Have you ever been kept from sleeping or awakened from sleeping by your pain?	YES	NO
Have you ever missed work or school due to your pain?	YES	NO

YOUR RESPONSES TO THE QUESTIONS BELOW ARE IMPORTANT TO EVALUATE YOUR EXPECTATIONS OF ANY TREATMENT WHICH MIGHT BE RENDERED.

Are you aware that improvement in symptoms may take weeks?	YES	NO
Are you aware that improvement in symptoms may be significant, minimal, or negligible?	YES	NO
Are you willing to wear the "splint" full-time, including while eating, if necessary?	YES	NO

HAVE YOU EVER HAD:

Persistent backaches?	YES	NO
Migraine headaches?	YES	NO
Arthritis?	YES	NO
Whiplash injury?	YES	NO
Ear operations?	YES	NO
Sinus operations?	YES	NO
Spastic colon?	YES	NO
Mouth ulcers?	YES	NO
Stomach ulcers?	YES	NO
High blood pressure?	YES	NO
Heart problems?	YES	NO
Stroke?	YES	NO
Any stress-related illness?	YES	NO
Any emotional or mental disease or disorder?	YES	NO
Any prescription medications for depression or tranquilizing?	YES	NO

DO YOU:

Bite your nails?	YES	NO
Bite or chew your cheeks?	YES	NO
Smoke?	YES	NO
Chew tobacco or dip snuff?	YES	NO
Chew food mostly on one side?	YES	NO
"Doodle" with your teeth (tap them together)?	YES	NO
"Play" with your jaw (move it excessively and unnecessarily by habit)?	YES	NO
Chew gum frequently?	YES	NO

Are you aware that regardless of how carefully a diagnosis is made, it is not possible to predict exactly what any individual's response will be to a given therapy?	YES	NO

(PLEASE GO ON TO PAGE 3 OF THIS QUESTIONNAIRE)

PATIENT "TMJ" QUESTIONNAIRE (page 3)

AS PERTAINS TO YOUR AREA OF GREATEST PAIN OR PROBLEM, CHECK THE APPROPRIATE BLANKS

CHARACTERISTIC OCCURS>>>	NEVER	OCCASIONAL	FREQUENT	ALWAYS
Touching or tapping causes pain				
Worse in morning				
Worse in afternoon or evening				
Awakens you at night				
Worse when moving jaws				
Lasts less than 5 minutes				
Feels like worms burrowing				
Feels like nails being driven				
Interferes with work or school				
Interferes with hobbies				
Has caused swelling				
Has caused redness or blushing				
Has caused blanching or whitening				
Causes you to cry easily				
Is uncomfortable, but not painful				
Hurts to yawn				
Hurts when eating				
Hurts on top of skull				
Hair roots seem to hurt				
Produces a numb feeling				
Produces paralysis of face				
Occurs when closing mouth				
Occurs when opening mouth				
Is in bone				
Is in soft tissues of face				
Is in Jaw-joint (TMJ)				
Is in ear				
Is in cheeks				
Is in nose				
Is in sinuses				
Is in teeth				
Is in soft tissues of mouth				
Is in eyes				
Is behind eyes				
Causes problem moving eyes				
Causes problem seeing				
Has produced pus				

(PLEASE GO ON TO THE 4TH AND FINAL PAGE OF THIS QUESTIONNAIRE)

PATIENT "TMJ" QUESTIONNAIRE (page 4)

PLEASE CIRCLE THE WORDS AND PHRASES BELOW THAT BEST DESCRIBE YOUR PAIN:

Steady	Occurs at the end of the day	Cold	Non-localized
Localized	Contracting	Severe	Moving
Heavy	Hot	Disabling	Light
Constant	Throbbing	Pinching	Blunt
Pulsating	Spreading	Hard	Not bothersome
Morning	Expanding	Numb	Fleeting
Varying	Exploding	Burning	Twisting
Hurts more when reclining	Deep	Tingling	Hurts more when standing
Constant	Dull	Short duration	Bothersome
Long duration	Horrible	Unbearable	Oppressive
Specific	Squeezing	Intermittent	Hurts more on weekdays
Often	Growing	Intense	Hurts more on weekends
Aching	Pressing	Cruel	Hurts more when awakening
Punishing	Hurts more when eating	Sharp	Hurts more when going to sleep
Piercing	Stabbing	Stretching	Nightmarish
Bearable	Persecuting	Electric	
General		Awakens you at night	

IN THE AREA PROVIDED BELOW, PLEASE SUMMARIZE ALL THE TREATMENT YOU HAVE RECEIVED FOR YOUR PROBLEM BEFORE COMING TO OUR OFFICE. PLEASE GIVE DOCTOR'S NAMES, APPROXIMATE DATES OF TREATMENT, WHAT TREATMENT WAS GIVEN, AND THE RESULTS OF THAT TREATMENT. INCLUDE ANY EXERCISES, MEDICATIONS, OCCLUSAL APPLIANCES, DENTAL TREATMENTS, PHYSICAL THERAPY, ETC, THAT MAY HAVE BEEN PRESCRIBED. IF YOU NEED MORE SPACE, PLEASE CONTINUE ON THE BACK OF THIS PAGE

SIGNATURE OF PATIENT OR GUARDIAN: ______________________________