

- Dr.
 Mr.
 Mrs.
 Miss
 Ms.

Date _____

Last

First

Middle

Temporomandibular joint (TMJ) problems can arise from a multitude of causes and be influenced by numerous factors. Your complete answers will assist us in making a correct diagnosis of your pain and dysfunction and help us develop a treatment plan that is appropriate for you.

- | | | | | |
|--|--------------------------------|---------------------------------------|-------------------------------------|---------------------------------|
| 1. Do your jaw joints make clicking or popping noises?
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |
| 2. Do your jaw joints make grating-like noises?
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |
| 3. Does your jaw ever lock open so that you cannot temporarily close it?
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |
| 4. Does your jaw get stuck momentarily so that you cannot fully open it?
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |
| 5. Do your jaws hurt or are your teeth sore in the morning when you awaken? | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |
| 6. Have you been recently told that you grind your teeth in your sleep? | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |
| 7. Are you aware of clenching your teeth together during the day? | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |
| 8. Does pain or discomfort from your jaw joint interfere with work or other activities? | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |
| 9. Do you have any pain in your facial muscles? | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |
| 10. Do you have any pain or soreness around or behind your eyes? | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |
| 11. Do you have problems with your ears such as ringing (tinnitus) or a recent change in hearing? | <input type="checkbox"/> never | <input type="checkbox"/> slight | <input type="checkbox"/> moderate | <input type="checkbox"/> severe |
| 12. Do you have ear pain or recurring ear infections?
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |
| 13. Do the muscles of your head, neck or shoulders feel tired, stiff or painful? | <input type="checkbox"/> never | <input type="checkbox"/> occasionally | <input type="checkbox"/> frequently | <input type="checkbox"/> always |

TMJ QUESTIONNAIRE-1 — PLEASE TURN PAGE

14. If present, how much does the pain of your head, neck or shoulder muscles bother you? not at all slightly moderately severely incapacitating
15. If present, how much does your jaw joint problem interfere with chewing? not at all slightly moderately severely incapacitating
16. If present, how much does your jaw joint problem interfere with your lifestyle? not at all slightly moderately severely incapacitating
17. Are you comfortable with the way your teeth fit together? YES NO
If NO, please describe. _____
18. Have you ever had orthodontic treatment? YES NO
19. Do you play a wind instrument or violin? YES NO
20. Do you engage in activities in which you wear a mouthpiece (i.e., scuba diving) or which require you to hold your jaw in an exaggerated position? YES NO
If YES, please explain. _____
21. Do you wear any dental appliance designed to improve the way your teeth fit together? YES NO
22. Have you ever had a whiplash injury? YES NO
If YES, please describe. _____
23. Have you ever received a severe blow to the side of your head or jaw? YES NO
 Right Left Both
If YES, please describe. _____
24. Have you ever had any other traumatic injury to your head or neck? YES NO
If YES, please describe. _____
25. If you have headaches, please indicate type and frequency.
 Muscle-contraction "tension" headaches never occasionally frequently always
 Sinus headaches never occasionally frequently always
 Migraine headaches never occasionally frequently always
 Other _____ never occasionally frequently always
26. Do you have arthritis in any of your joints? YES NO
If YES, which joints? _____
Which type of arthritis do you have and how severe is it?
 Osteoarthritis mild moderate severe incapacitating
 Rheumatoid arthritis mild moderate severe incapacitating
 Other _____ mild moderate severe incapacitating
List any medications you take for your arthritis: _____
27. Do you suspect that your arthritis also involves the jaw joints? YES NO
 Right Left Both

TMJ QUESTIONNAIRE-2—PLEASE TURN PAGE

28. Are you troubled with insomnia? YES NO
29. Are you currently under a great deal of stress? YES NO
 Work Family Social
30. Are there times when you notice your problem or pain is less or gone completely? YES NO
31. Are you afraid that your problem is serious? YES NO
32. Do you feel you need treatment for the problem? YES NO
33. Please describe the nature of your pain or dysfunction, how and when it began, the present level of discomfort, and the limitations it places on your activities.

34. List chronologically all health professionals you have seen for this problem.

Date	Name	Type of Practitioner	Treatment Received	Results

35. List all medications you are taking or have taken for this problem.

Medication	Prescribed By Whom	Date	Results	Currently Taking Medication?
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO