TMJ DYSFUNCTION QUESTIONNAIRE

Patient_____Age_____Occupation_____Date_____

Referred by _____Phone ( )_____
Others who are or have been treating this problem:
Doctor_____
Address_____

Doctor_____
Address_____

What type of treatment have you had for this problem/pain?

Medicines:_____
_____
Physical Therapy:_____
Occlusal Adjustments:_____
Splints:_____
How many?_____

Orthotics:_____
Orthodontics:_____
Surgery:_____
Counseling:_____
Other:_____

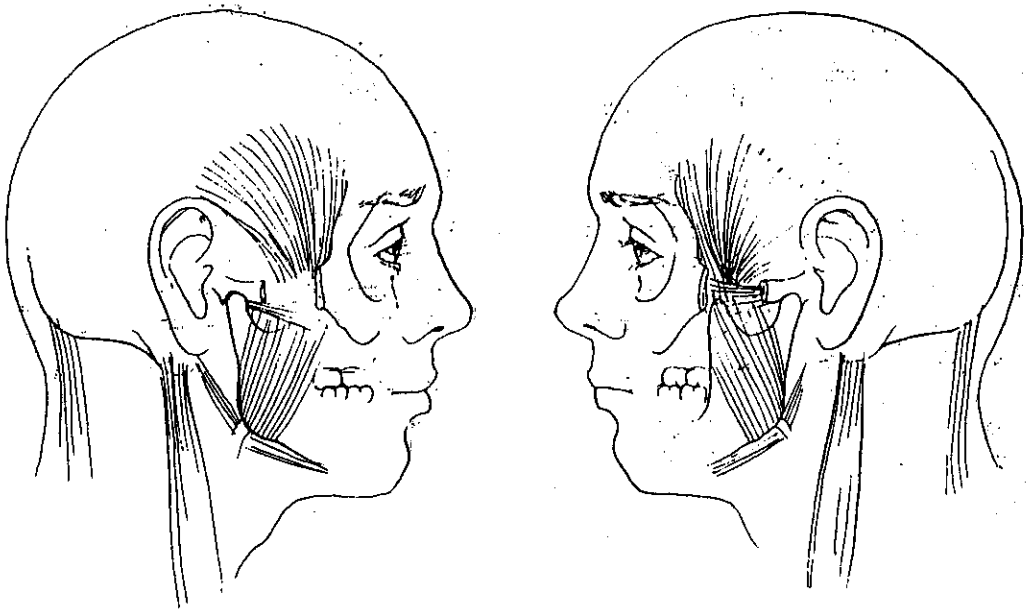
General Symptoms

1. Describe your problem:_____
_____
_____

2. How long has this problem been present?_____

3. Is it located in the right_____, left_____, both sides_____, neither_____.

4. Draw an outline or shade the area of your pain.



5. On the scale below mark where your pain falls at its worst. (X)

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0                25                50                75                100
|----------------|----------------|----------------|----------------|
No                                                                  Worst Pain
Pain                                                                Imaginable
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6. ___yes ___no Does the pain or discomfort limit your ability to chew certain foods?
7. ___yes ___no Is the pain constant or recurring? rt_____ lt_____
8. ___yes ___no Intermittent pain? rt_____ lt_____
9. ___yes ___no Burning pain? rt_____ lt_____
10. ___yes ___no Dull, aching pain? rt_____ lt_____
11. ___yes ___no Stabbing, severe pain? rt_____ lt_____
12. ___yes ___no Electrical, shooting pain? rt_____ lt_____
13. ___yes ___no Does it hurt when you chew?
    Where?_____
14. ___yes ___no Does it hurt to move your jaw?
15. ___yes ___no Does the pain/problem interfere with daily activities?
    If so, how?_____
16. ___yes ___no Does it hurt to open wide or take a big bite?
17. ___yes ___no Does your jaw click or pop when chewing?
    right_____ left_____
18. ___yes ___no Does anything you do make the pain worse?
    What?_____
19. ___yes ___no Does anything you do make the pain better?
    What?_____
20. ___yes ___no Do you suffer from chronic headaches?
    How often?_____
    Location_____
21. ___yes ___no Is the condition worse in the morning____, during the day____,
    in the evening_____, during sleep_____, after eating_____,
    after speaking_____?
22. ___yes ___no Do you grind your teeth in your sleep?
23. ___yes ___no Do you clench your teeth during the day?
24. ___yes ___no Have you ever had chronic neck____, shoulder____, or back____ pain?
    How long?_____

25. ___yes ___no Do you notice any of the following?

____	Hearing loss	rt_____ lt_____
____	Pain in teeth in AM	rt_____ lt_____
____	Headaches	rt_____ lt_____
____	Neck Pains	rt_____ lt_____
____	Popping, clicking or grating of the jaw	rt_____ lt_____
____	Stuffiness in ears	rt_____ lt_____
____	Ringing in ears	rt_____ lt_____
____	Dizziness	yes____ no____
____	Swallowing difficulty	yes____ no____

Medical History

1. ___yes ___no Was there any event which you believe may have helped cause this problem/pain?
   If so, please describe
   Accident/Trauma:_____ Dental Treatment:_____
   Surgery:_____ Stress:_____
   Other:_____
   _____
2. ___yes ___no Have you ever had a whiplash? When?_____
   Any treatment?_____
3. ___yes ___no Have you ever had "nervous stomach" or ulcers? If so, how long?_____
   Taking medications?_____
4. ___yes ___no Are you under medical treatment? If yes, for what?_____

Dental History

1. ___yes ___no Are any of your teeth worn badly_____, very loose_____, sore_____?
2. ___yes ___no Have you had teeth extracted within the past three years?
3. ___yes ___no Recent fillings _____?
   Recent bridges/crowns _____?
   Other_____
4. ___yes ___no Have you worn braces or had your teeth straightened? If so, age?_____