

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: _____