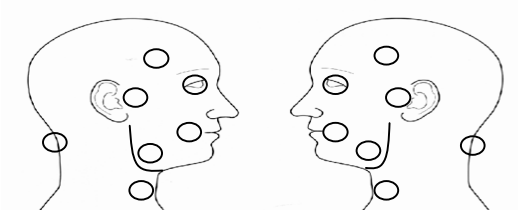
TMJ AND FACIAL PAIN PROBLEM QUESTIONNAIRE

1. Name_____ Age_____
   Date_____ Referred by _____

2. Which of the following do you have (circle all that apply)
   Headaches Neck pain Jaw pain Ear pain Facial pain Sensitive teeth
   Other_____
   Describe your pain_____

3. Place an (x) in the circle(s) where you hurt.



RIGHT SIDE LEFT SIDE

4. How long have you had this pain? _____
   Is the pain constant?_____
   Is the pain (circle all that apply)
   Aching Burning Stabbing Other _____
   Please rate your pain on a scale of 1 to 10 Mild 1 2 3 4 5 6 7 8 9 10 Severe

5. When is the pain the worst in the (circle all that apply)
   Morning Afternoon Evening Night

6. What makes the pain better?_____
   What makes the pain worse? _____
   What medication(s) do you take or have you previously taken for your pain?
   MEDICATION DOSE FREQUENCY
   _____
   _____
   _____
   _____

7. Does it hurt to chew? ☐ Yes ☐ No
   Does it hurt to open wide? ☐ Yes ☐ No
   Which side of your jaw makes a popping noise? ☐ Left ☐ Right
   Which side of your jaw makes a clicking noise? ☐ Left ☐ Right
   Which side of your jaw makes other noises? ☐ Left ☐ Right
   What noises? _____
   When did you first notice joint noises? _____

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8. Has your jaw ever locked? ☐ Yes ☐ No
   Did it lock open or closed? ☐ Open ☐ Closed
   When did this first happen?_____
   When did this last happen?_____
   Has your jaw ever slipped out of place? ☐ Yes ☐ No
   Which side? ☐ Left ☐ Right

9. Have you noticed any change in your bite? ☐ Yes ☐ No
   Can you describe the changes_____
   Did you notice a change at your front teeth? ☐ Yes ☐ No
   Did you notice a change at your back teeth? ☐ Yes ☐ No
   Has your profile changed? ☐ Yes ☐ No
   Is there crookedness or asymmetry in your jaw? ☐ Yes ☐ No
   When did you notice asymmetry?_____

10. Are your teeth sore or sensitive? ☐ Yes ☐ No
    Do you clench your teeth? ☐ Yes ☐ No
    Do you grind your teeth? ☐ Yes ☐ No
    Do you do this during the day or night? ☐ Day ☐ Night
    When did you start clenching or grinding?_____

11. Do you have problems with your ears? ☐ Yes ☐ No
    Dizziness ☐ Yes ☐ No
    Ringing ☐ Yes ☐ No
    Hearing ☐ Yes ☐ No
    Other_____

12. Is this condition a result of an accident? ☐ Yes ☐ No
    If yes, date of the accident _____
    Please describe_____
    _____

13. Have you ever been injured by a blow to the jaw? ☐ Yes ☐ No
    When (year)_____
    Please describe_____
    _____

14. Are you aware if you grind or clench your teeth? ☐ Yes ☐ No
    Do you grind or clench your teeth at night? ☐ Yes ☐ No
    Do you grind or clench your teeth during the day? ☐ Yes ☐ No

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15. Do you have trouble getting to sleep? ☐ Yes ☐ No
    Do you sleep well? ☐ Yes ☐ No

16. Do you consider yourself to be under a lot of stress? ☐ Yes ☐ No

17. Are you nervous or anxious about anything? ☐ Yes ☐ No
    Have you ever had a nervous stomach, ulcers, skin disease?
    ☐ Yes ☐ No

18. Do you have or have ever had arthritis?_____
    Does your pain keep you from doing anything? _____
    If yes, what? _____
    _____

19. Have you had any prior treatment for TMJ?

Splint	☐ Yes	☐ No	When_____
Did it help	☐ Yes	☐ No	
Night guard	☐ Yes	☐ No	When_____
Did it help	☐ Yes	☐ No	
Bite adjustment	☐ Yes	☐ No	When_____
Did it help	☐ Yes	☐ No	
Orthodontics	☐ Yes	☐ No	When_____
Did it help	☐ Yes	☐ No	
Medication	☐ Yes	☐ No	When_____
Did it help	☐ Yes	☐ No	
Physical Therapy	☐ Yes	☐ No	When_____
Did it help	☐ Yes	☐ No	
Counseling	☐ Yes	☐ No	When_____
Did it help	☐ Yes	☐ No	
Surgery	☐ Yes	☐ No	When_____
Did it help	☐ Yes	☐ No	

Other _____

20. I have completed the above questionnaire to the best of my knowledge.

Signature_____ Date_____