

TMJ INFORMATION

Date: ___/___/___

1. Name _____ 2. Age _____

3. Referred by _____

4. Describe your problem _____

5. How long has this pain/problem been present? _____

6. 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: _____

7. Is the pain CONSTANT or INTERMITTENT? (Circle one)

8. Does it hurt to move your jaw? _____

chew? _____

9. Does the pain/problem limit your function? _____

If so, how? _____

10. When is the pain worse? Morning Afternoon Evening (Circle one)

Other time: _____

11. Does anything you do make the pain worse? _____

What? _____

12. Does anything you do make the pain better? _____

What? _____

13. What other doctors or health care associates have you seen regarding this pain/problem?

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

Medicines: _____ Orthotics: _____

Orthodontics: _____

Physical Therapy: _____ Surgery: _____

Occlusal Adjustments: _____ Counseling: _____

Splints: _____ Other: _____

How many? _____

15. Does your joint/jaw make noise? _____ Has it ever? _____ Click? _____

Grind? _____ Other _____ When? _____ For how long? _____

16. Does your jaw ever lock open? _____ Closed? _____

How has this been treated? _____

Can you do anything to prevent or treat this? _____

17. Do you grind or grit your teeth? _____

18. Do you have or have you had any of the following? (Please Check Y or N)

	Y	N		Y	N		Y	N		Y	N
Sinus Problems			Hearing Changes			Stressful Job			Migraines		
Sensitive Teeth			Ringing in Ears			Marital Problems			Arthritis		
Periodontal Disease			Dizziness			Trouble Sleeping			Home Stress		
Headaches			Shoulder Pain			Ulcers			Ear Ache		
Neck Ache			Skin Disease			Nervous Stomach			Depression		
Allergies			To what?(please list)								

List other medical problems _____

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