Please answer ALL questions

For patients with TMJ/jaw pain, please be aware that if a temporary device is fabricated for you at your initial visit or a follow up visit, there will be a fee associated. Fees range from $20 to $125 and will be due at the time the device is made.

1. Name_______________________________________ Age_____________ Date______________

2. Which of the following do you have (circle all that apply)

   Headaches Neck pain Jaw pain Ear pain Facial pain Other_________________________

   Which side hurts (circle one) Right Left Both

3. How long have you had this pain?____

   Is the pain constant?____

   Is the pain (circle all that apply) Aching Burning Stabbing Other_________________

4. Is the pain the worst in the (circle all that apply) Morning Afternoon Evening Night

5. Have you ever injured or sustained any form of trauma or whiplash to your (circle all that apply)

   Jaw Head Neck

6. What makes the pain better?____

____

What makes the pain worse?____

____

7. What medication (s) do you take or have you previously taken for your pain?

MEDICATION	DOSE	FREQUENCY

8. Please circle appropriate answer for the following questions:

- 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?

  ____

  ____

9. Please circle appropriate answer for the following questions:

• 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

10. Please circle appropriate answer for the following questions:

• Have you noticed a change in your bite?	Yes	No
• 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
• Have you noticed any crookedness or asymmetry in your jaw?	Yes	No

- When did you notice the asymmetry?______________________________________

11. Please circle appropriate answer for the following questions:

• 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?__________________________________

12. Please circle appropriate answer for the following questions:

• Do you have problems with your ears?	Yes	No
• Dizziness?	Yes	No
• Hearing?	Yes	No

13. Please circle appropriate answer for the following questions:

• Is it difficult to swallow?	Yes	No
• Is it painful to swallow?	Yes	No
• Have you noticed lumps in your face?	Yes	No
• Have you noticed lumps in your throat?	Yes	No
• Have you noticed lumps in your neck?	Yes	No

- Have you noticed lumps elsewhere?______________________________________

14. Please circle appropriate answer for the following questions:

• Have you had any prior treatment for TMJ?	Yes	No
• Splint	Yes	No
• Nightguard	Yes	No
• Bite Adjustment	Yes	No
• Orthodontics	Yes	No

- Other?

____

____

15. Describe the problems in your own words as you understand them:

____
____
____
____

16. Reports may be sent to my:

- Medical Doctor____
- Dentist ____
- Other ____

____

Please Print Name

____

Patient Signature

____

Date