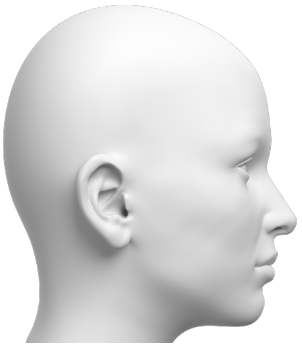
Temporomandibular Joint Dysfunction (TMJ)
Questionaire

Name:

Age:

1	Describe your problem.			
2	Which side hurts?	Right ◯	Left ◯	Both ◯
3	Is the pain constant or intermittent?		Constant ◯	Intermittent ◯
4	When is the pain worse?	Morning ◯	Afternoon ◯	Evening ◯
5	Does it hurt to move your jaw?		Yes ◯	No ◯
6	Does it hurt to chew?		Yes ◯	No ◯
7	On the figures, please outline where your pain is located.	Right Side 	Left Side 	
8	Does your jaw make noise?		Yes ◯	No ◯
9	Has your jaw ever locked open?		Yes ◯	No ◯
10	Has your jaw ever locked closed?		Yes ◯	No ◯
	If yes (9 &10): when & how often?			
11	If your jaw does not make noise or lock now, has it in the past?		Yes ◯	No ◯
12	Have you ever suffered from?	Ear Pain ◯	Change in hearing ◯	Dizziness ◯
		Shoulder Pain ◯	Headaches ◯	Neck aches ◯

13	Do you grind or clench your teeth?	During daytime ◯	Yes ◯	No ◯
14	Do you have sore or sensitive teeth?		Yes ◯	No ◯
15	Do you have trouble falling asleep?		Yes ◯	No ◯
16	Do sleep well?		Yes ◯	No ◯
17	Do you consider yourself to be under a lot of stress?		Yes ◯	No ◯
18	Are you nervous or anxious about anything?		Yes ◯	No ◯
19	Have you had nervous stomach, ulcers, or skin disease?		Yes ◯	No ◯
20	Do you have or have you had arthritis?		Yes ◯	No ◯
21	Does your pain keep you from doing anything?		Yes ◯	No ◯
22	Can you remember any injury to your jaw?		Yes ◯	No ◯
23	Do you take medication for the pain?		Yes ◯	No ◯
24	Do you take medication for relaxation?		Yes ◯	No ◯
25	Have you ever had any treatment for your problem?		Yes ◯	No ◯
26	If yes (25) What treatments have you had?	Medication ◯	Surgery ◯	Bite Splint ◯
	Physical Therapy ◯	Consultation ◯	Occlusal Adjustment ◯	Other (specify below) ◯
	If other, please specify:			

27	Rate your current pain level.	(circle a number)	1 2 3 4 5 6 7 8 9 10
28	At it's worst, what level was the pain?	(circle a number)	1 2 3 4 5 6 7 8 9 10

Signature:

Date Submitted:

Notes: