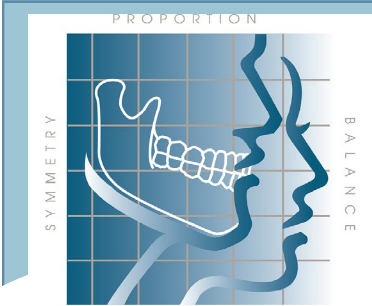

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TMJ PROBLEM QUESTIONNAIRE

Do Not Write In This Section

1 Name: ______________________ Age: ________

Date: ____________ Referred By: ____________________

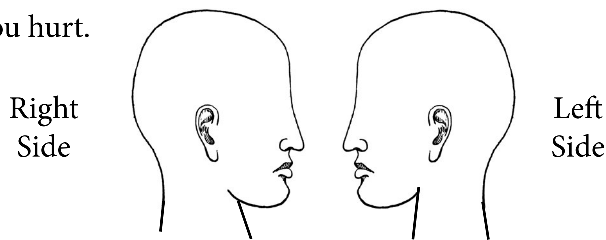
2 Which of the following do you have? (check that apply)

Headaches Neck Pain Jaw Pain Facial Pain

Other: ______________________________

Which side hurts? (check that apply) Left Right Other

3 Place an (X) in the circles where you hurt.



4 How long have you had this pain? ____________________

Is the pain constant? ____________________

Is the pain (check all that apply) Aching Burning Stabbing

Other: ____________________

5 Is the pain worse (check that apply)

Morning Afternoon Evening Night

6 Have you ever injured or sustained any form of trauma or whiplash to your (check all that apply) Jaw Head Neck

(If so, please completed the trauma questionnaire)

7 What makes the pain better? ____________________

What makes the pain worse? ____________________

What medication do you take or have you previously taken for your pain?

MEDICATION	DOSE	FREQUENCY

Your Name: ______________________________

Do Not Write In This Section

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

9. Has your jaw ever locked? Yes No
Did it lock open or closed? (check one) Opened Closed
When did this first happen? ______________________________
When did this last happen? ______________________________
Has your jaw ever slipped out of place? Yes No
Which side? Right Left

10. 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. 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. Do you have problems with your ears? Yes No
Dizziness? Yes No Ringing? Yes No
Hearing? Yes No Other? ______________________________

13. Is it difficult to swallow? Yes No
Is it painful to swallow? Yes No
Have you noticed lumps in your face?
Throat? Yes No Neck? Yes No Other? ______________________________

14. Have you had any prior treatment for TMJ? Yes No

Splint?	Yes	No	When? ________	Did it help?	Yes	No
Nightguard?	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

Other? ______________________________

Your Name: ____

Do Not Write In This Section

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

____

____

____

____

____

16. Reports may be sent to my...

Medical Doctor: ____
(Name)

Dentist: ____
(Name)

Other: ____
(Name)

17. I have completed the above to the best of my knowledge and I personally have filled in each blank in my own writing. I consent to the use of my X-rays, records, and photos for Scientic publication or teaching providing my name remains anonymous.

Signature: ____

Date: ____