TMJ PROBLEM QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS	DO NOT WRITE IN THIS SPACE

I. NAME _____ ____ AGE _____

DATE _____ _____

REFFERED BY _____

II. DO YOU HAVE HEADACHES? _____ NECK PAIN? _____

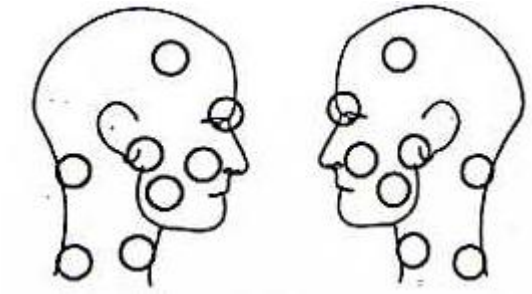
JAW PAIN? _____EAR PAIN? _____ FACIAL PAIN? _____

OTHER? _____

WHICH SIDE

RIGHT? _____ LEFT? _____ BOTH? _____

III. PLACE A (✓) IN THE CIRCLE THA IS CLOSEST TO THE AREA WHERE YOU HURT THE MOST.



RIGHT SIDE LEFT SIDE

IV. HOW LONG HAVE YOU HAD THIS PAIN? _____

IS THE PAIN CONSTANT? _____

WOULD YOU DESCRIBE THE PAIN AS:

ACHING? _____ BURNING? _____ STABBING? _____

OTHER? _____

V. IS THE PAIN WORSE: MORNING? _____ AFTERNOON? _____

AWAKE? _____ WHILE SLEEPING? _____

VI. HAVE YOU EVER INJURED OR STATAINED ANY FORM OF TRAUMA OR WHIPLASH TO YOU:

JAW? _____ HEAD? _____ NECK? _____

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VII. WHAT MAKES THE PAIN WORSE? _____ WHAT MAKES THE PAIN BETTER? _____ _____ WHAT MEDICATION DO YOU TAKE FOR YOUR PAIN? MEDICATION DOSE FREQUENCY _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ VII: DOES IS HURT TO CHEW? _____ OPEN WIDE? _____ WHICH SIDE OF THE JAW MAKES A POPPING NOISE? _____ CLICKING? _____ _GRINDING? _____ OTHER NOISE? _____ X. HAVE YOU NOTICED A CHANGE IN YOUR BITE? _____ FRONT TEETH? _____ BACK TEETH? _____ HAS YOUR PROFILE CHANGED? _____ _____ XI. ARE YOUR TEETH SORE OR SENSITIVE? _____ DO YOU CLENCH YOUR TEETH? _____ GRIND? _____ DURING THE DAY? _____ AT NIGHT? _____ WHEN DID YOU START DOING THIS? _____ XII. DO YOU HAVE PROBLEMS WITH YOUR EARS? _____ DIZZINESS? _____ RINGING? _____ HEARING? _____ OTHER? _____	

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XII. IS IT DIFFICULT TO SWALLOW? _____ PAINFUL TO SWALLOW? _____ HAVE YOU NOTICED ANY LUMMPS IN YOUR: FACE? _____ _THROAT? _____ NECK? _____ OTHER? _____ XIV. HAVE YOU HAD ANY PRIOR TREATMENT FOR THIS PROBLEM? _____ SPLINT? _____ ___ DID IT HELP? _____ NIGHTGUARD? _____ DID IT HELP? _____ BITE ADJUSTMENT? _____ DID IT HELP? _____ ORTHODONTICS? _____ DID IT HELP? _____ OTHER? _____ XV. DESCRIBE THE PROBLEM IN YOUR WORDS AS YOU UNDERSTAND IT. _____ _____ _____ _____ XVI. REPORTS MAY BE SENT TO MY: (NAME) MEDICAL DOCTOR _____ DENTIST _____ OTHER _____ XVII. 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 SCIENTIFIC PUBLICATION OR TEACHING PROVIDING NAME REMAIS ANYONMOUS. _____ SIGNATURE	