Name _____

Date _____

TMJ HISTORY AND SYMPTOMS

Please fill out completely.

Briefly describe your problem: _____

_____

How long have you had this problem?

_____ weeks _____ months _____ years

What, specifically, is prompting you to seek treatment today? _____

_____

Does this problem occur:

❑ constantly? ❑ daily? ❑ weekly? ❑ monthly?

Are your symptoms worse:

❑ in the a.m.? ❑ in the p.m.? ❑ while eating?

❑ at any other time? Explain: _____

If your symptoms include pain, is the pain: (check *all* that apply)

❑ dull, aching? ❑ continuous? ❑ sharp, stabbing?

❑ intermittent? ❑ throbbing? ❑ pressure?

❑ other: _____

Please rate pain on a scale of 0-10 (0 being no pain; and 10 very severe pain) _____

Please answer all questions by circling correct answer.

1. Has anything occured in your life which might be related to the onset of this problem? Yes No

   Check all that apply:

   ❑ Sleep Loss ❑ Fatigue ❑ Anxiety

   ❑ Irritability ❑ Frustration ❑ Depression

   ❑ Crying Spells ❑ Mood Swings ❑ Tension

   ❑ Recent Weight Loss ❑ Suicidal Thoughts ❑ Excessive Perspiration

   ❑ Palpitation ❑ Faintness

   Present or previous psychotherapy Yes No

   Explain: _____

2. Do you feel that this problem has affected your hearing? Yes No

3. Does this problem interfere with your normal activities? Yes No

   Explain _____

4. Have you ever taken any medication for this problem? Yes No

   If so, what? _____

5. Do you have difficulty chewing? Yes No

   Because of: ❑ Pain in joint ❑ Limited opening

   ❑ Pain in teeth ❑ Missing teeth

   ❑ Clicking ❑ Other _____

6. Has your jaw ever locked in an open position? Yes No

   Explain: _____

7. Have you ever had difficulty opening your mouth? Yes No

   Explain: _____

8. Are you ever aware of clenching your teeth? Yes No

   If so, when? _____

9. Do you grind your teeth? Yes No

   If so, when? _____

10. Are your teeth or chewing muscles sore when you awake? Yes No
❑ Regularly ❑ Occasionally ❑ Rarely

11. Do you have any ringing noises in your ears? Yes No

12. Do you have any loose joint problems? (i.e. double-jointed arms, fingers, etc.) Yes No
Explain: _____

13. Do you have arthritis in any of your joints? Yes No

14. Have you had any problems with other joints? Yes No
Explain: _____

15. Has there been a recent major change in your life? (i.e. divorce, childbirth, career change, death of a close friend or relative, etc.) Yes No

16. Have you suffered any injury or trauma to your jaw, face, neck or back? Yes No
Describe and indicate date(s) _____

17. Have you previously received any medical or dental treatment for this problem? Yes No
Please list approximate date of treatments:

Medication _____ Maxillary orthopedic splint _____
Physiotherapy _____ Mandibular orthopedic splint _____
X-Rays _____ Occlusal equilibration _____
Catscan _____ Occlusal rehabilitation _____
Surgery - TMJ _____ Psychotherapy _____
Other surgery _____ Chiropractic _____
Other _____
Explain _____

18. Have you ever had orthodontic treatment or braces? Yes No
When? _____ Where? _____

19. Have you had any dental treatment recently? Yes No
When? _____ Explain: _____

Please circle all words that apply:

PAIN

Joint Pain:	Right Side	Left Side	Both
Muscle Pain:	Right Side	Left Side	Both
Neck Pain:	Right Side	Left Side	Both
Back Pain:	Right Side	Left Side	Both
Headaches:	Right Side	Left Side	Both

Front of Head Back of Head How many headaches per week?

NOISES

Clicking joint:	Right Side	Left Side	Both
Grinding joint:	Right Side	Left Side	Both
Popping joint:	Right Side	Left Side	Both

When did you first noice the noise? _____
Have the characteristics of the noise change recently? Yes No
Please describe: _____

On the lines below, please list any physicians; dentists, neurologists, ENT's, orthopedists, therapists, chiropractors or other practitioners who have treated you for this problem and briefly describe their diagnosis and treatment.

A. Dr. _____ Specialty _____
Address _____ Phone _____
Diagnosis and treatment _____

B. Dr. _____ Specialty _____
Address _____ Phone _____
Diagnosis and treatment _____