

Temporomandibular Joint Dysfunction (TMJ) Questionnaire

Name: _____

Age: _____

Referred by: _____

1 Describe your problem:

2 Which side hurts?

Right

Left

Both

For how long:

3 Is the pain constant or intermittent?

4 When is the pain worse?

Morning

Afternoon

Evening

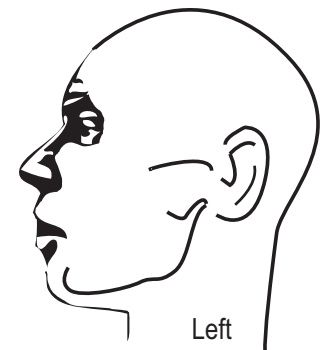
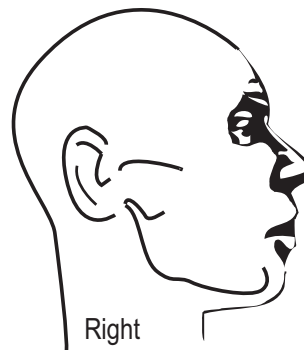
5 Does it hurt to move your jaw?

Yes No

6 Does it hurt to chew?

Yes No

7 On the figures to the right, please outline where your pain is located.



8 Does your jaw make noise?

Clicking

Grinding

Other

When:

For how long:

9 Has your jaw ever locked open?

Yes No

10 Has your jaw ever locked closed?

Yes No

When:

How often:

11 If your jaw does not make noise or lock now, has it ever in the past?

Yes No

12 Have you ever suffered from?

Headaches

Neckaches

Shoulder Pain

Ear Pain

Dizziness

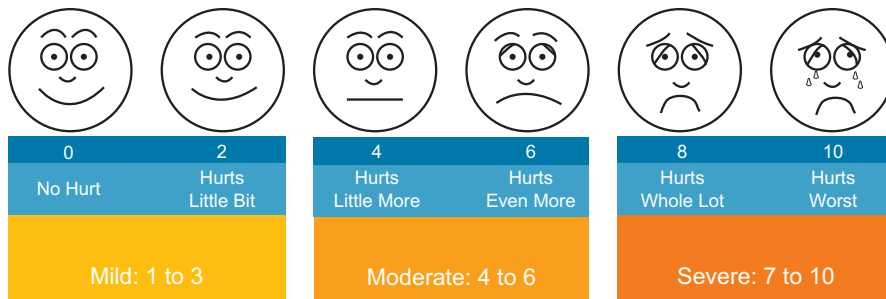
Change in Hearing

Turn over...

- 13 Do you grind or clench your teeth? At night During the day
- 14 Do you have sore or sensitive teeth? Yes No Sometimes
- 15 Do you have trouble getting to sleep? Yes No Sometimes
- 16 Do you sleep well? Yes No Sometimes
- 17 Do you consider yourself to be under a lot of stress? Yes No Sometimes
- 18 Are you nervous or anxious about anything? Yes No Sometimes
- 19 Have you had a nervous stomach, ulcers, skin disease? Yes No Sometimes
- 20 Do you have or have you ever had arthritis? Yes No Sometimes
- 21 Does your pain keep you from doing anything? Yes No If yes, what?
- 22 Can you remember any injury to your jaw? Yes No If yes, describe:
- 23 Do you take medications for the pain? Yes No If yes, what?
- 24 Do you take medications for relaxation? Yes No If yes, what?
- 25 Have you had any treatments for your problem? Yes No
- 26 Please check any treatments you have had:

- Bite splint
- Medication
- Physical therapy
- Counseling
- Occlusal adjustment
- Orthodontics
- Surgery
- Other:

27 Rate your pain now:



28 At its worst, how bad was the pain?

