TMJ HEALTH QUESTIONNAIRE

CHIEF COMPLAINT ______________________________

DO YOU FEEL YOU NEED TREATMENT FOR THIS PROBLEM? Y N

DATE OF ONSET ______________________________

PAIN SYMPTOMS

Do you get "tension headaches"? Y N

Do you ever get "migraine headaches"? Y N

Do you frequently have neckaches or stiff neck muscles? Y N

Do you have trouble sleeping soundly? Y N

Have your teeth been sore upon awakening? Y N

Does your jaw ache when you chew? Y N

Do you have ear pain? Y N

Does your jaw ache when you open wide? Y N

Have you ever had chronic shoulder or back pain? Y N

What medication, if any, are you taking?

____

____

Do you get headaches in right or left temple areas? Y N

Do you get headaches in the back of your head? Y N

Do you grind your teeth when asleep? Y N

Are your jaws tired when you awaken from sleep? Y N

When are your symptoms the worse? ______________________________

____

Does anything make you feel better? ______________________________

____

How often do you take medicine for relief of pain?

a) Never b) Weekly to Monthly

c) Weekly d) Daily

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw? Y N

Any whiplash neck injuries? Y N

Have you ever been involved in any serious accidents, such as a car accident? Y N

Details ______________________________

____

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal? Y N

Are there any foods you avoid eating? Y N

Do you ever get dizzy? Y N

Do you ever feel faint? Y N

Do you ever feel nauseated (sick)? Y N

Is there a family history of jaw joint (TMJ) problems or headaches? Y N

Do you feel or hear a "clicking", "popping" or "cracking" noise from either jaw joint? Y N

Has your jaw ever locked where you were unable to open or close? Y N

Do you have difficulty opening wide or yawning? Y N

Have you ever had pain in either jaw joint? Y N

EAR AND EYE SYMPTOMS

Do you have itchiness or stuffiness in either ear? Y N

Do you suffer from any loss of hearing? Y N

Do you get pain in, around or behind either eye? Y N

Are there times when your eyesight blurs? Y N

Do you wear glasses or contacts? Y N

Do you have any pain in your ears? Y N

Do you hear ringing, buzzing or hissing sounds in either ear? Y N

Do you hear grating noises in ears? (like sand particles rubbing) Y N

BREATHING

Do you have allergies? Y N

Do you have sinus problems? Y N

Do you snore at night? Y N

Is your nose stuffed when you don't have a cold? Y N

TMJ EXAMINATION Initial Exam Date ____________

RANGE OF MOTION MEASUREMENTS

Maximum Interincisal Opening

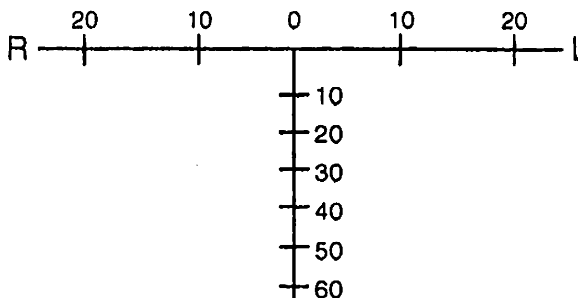
Maximum Opening ______ mm. + Overbite ______ mm. = ______ mm

Maximum Opening ______ mm. - Open Bite ______ mm. = ______ mm

73

Right Lateral Movement ______ mm

Left Lateral Movement ______ mm



Protrusive Movement ______ mm

Deflection/Deviation to Left on Opening

Deflection/Deviation to Right on Opening

No Deviation/Deflection

JOINT PALPATION

No Pain	No Clicking	No Crepitus	No Popping
Pain on Left	Clicking on Left	Crepitus on Left	Popping on Left
Pain on Right	Clicking on Right	Crepitus on Right	Popping on Right

MUSCLE PALPATION

√= No Pain X = Uncomfortable O = Pain OO = Severe Pain

Date	Initial		Update		Final	
Extra-Oral	Right	Left	Right	Left	Right	Left
Posterior TMJ	___	___	___	___	___	___
Vertex	___	___	___	___	___	___
Sinus	___	___	___	___	___	___
Occipital	___	___	___	___	___	___
Posterior Neck	___	___	___	___	___	___
Trapezius	___	___	___	___	___	___
Anterior Digastric	___	___	___	___	___	___
Posterior Digastric	___	___	___	___	___	___
Sternocleidomastoid	___	___	___	___	___	___
Anterior Temporalis	___	___	___	___	___	___
Medial Temporalis	___	___	___	___	___	___
Posterior Temporalis	___	___	___	___	___	___
Superficial Masseter	___	___	___	___	___	___
Deep Masseter	___	___	___	___	___	___
Intra-Oral						
Masseter Body	___	___	___	___	___	___
Lateral Pterygoid	___	___	___	___	___	___
Medial Pterygoid	___	___	___	___	___	___
Range of Motion						
Maximum Opening	___	___	___	___	___	___
Right Lateral Movement	___	___	___	___	___	___
Left Lateral Movement	___	___	___	___	___	___
Protrusive Movement	___	___	___	___	___	___
Deflection/Deviation on Opening	___	___	___	___	___	___
Clicking on Opening	___	___	___	___	___	___
Pain on Opening	___	___	___	___	___	___