TMJ QUESTIONNAIRE

Patient _____ DOB_____ Today's Date _____

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Please check yes or nor to the following questions and describe when indicated. This will help us understand your present and past medical history. This information will maximize the safety and effectiveness of your evaluation and/or treatment and is strictly confidential.

GENERAL MEDICAL HISTORY

Do you have pain on opening your mouth?	☐ Yes	☐ No
Do you have pain on closing your mouth?	☐ Yes	☐ No
Do you have pain in the fully opened position?	☐ Yes	☐ No
Do you have pain biting a firm object?	☐ Yes	☐ No
Do you have pain with eating?	☐ Yes	☐ No
Do you have pain with chewing?	☐ Yes	☐ No
Right___ Left ___ Both ___		
Do you have stiffness on waking, pain with function that decreases as the day goes by?	☐ Yes	☐ No
Do you have pain with a yawn?	☐ Yes	☐ No
Do you have pain when biting?	☐ Yes	☐ No
Do you have pain with chewing?	☐ Yes	☐ No
Do you have pain with swallowing?	☐ Yes	☐ No
Do you have pain with speaking?	☐ Yes	☐ No
Do you have pain with shouting?	☐ Yes	☐ No
Do you breathe through your nose?	☐ Yes	☐ No
Do you breathe through your mouth?	☐ Yes	☐ No
Do you have any clicking of your jaw?	☐ Yes	☐ No
Has your mouth or jaw ever locked?	☐ Yes	☐ No
Open___ Closed___		
Do you have any of the following habits?		
Pipe smoking?	☐ Yes	☐ No
Using a cigarette holder?	☐ Yes	☐ No
Leaning on your chin?	☐ Yes	☐ No
Chewing gum?	☐ Yes	☐ No
Biting nails?	☐ Yes	☐ No
Chewing hair?	☐ Yes	☐ No
Pursing and chewing lips?	☐ Yes	☐ No
Continually moving mouth?	☐ Yes	☐ No
Any other nervous habits?	☐ Yes	☐ No
Do you grind your teeth or hold them tightly?	☐ Yes	☐ No
Are any teeth missing?	☐ Yes	☐ No
If yes, which ones? _____		
Are any teeth painful or sensitive?	☐ Yes	☐ No
Do you hold your head in any particular posture?	☐ Yes	☐ No
Have you noticed any voice changes?	☐ Yes	☐ No
Do you wear a dental splint?	☐ Yes	☐ No

Have you seen a dentist? ☐ Yes ☐ No

If yes, what were the results? _____

Are there any activities/hobbies/self-care/or work related duties that you are unable to perform? ☐ Yes ☐ No

Have you ever had surgery? ☐ Yes ☐ No

If so, tell when, what type, and outcome_____

_____

How do you think you learn best? (Check all that apply)

☐ Seeing (reading written material or viewing i.e., booklet, brochure, slides, video, pictures)

☐ Listening (tape, lecture, or presentation)

☐ Doing (by actually perform ing the activity or doing the task)

☐ Not sure

Attitude Towards Problem

☐ No problem

☐ Minor inconvenience

☐ Slight problem

☐ Moderate problem

☐ Major problem

Confidence in Controlling Your Problem

☐ Complete confidence

☐ Moderate confidence

☐ Little confidence

☐ No confidence

What goals to you hope to achieve in this program?_____

_____

List any other information that you feel would be helpful on your evaluation: _____

_____

_____

Signature _____ Date _____