SADDLE ROCK INSTITUTE

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Temporomandibular Joint (TMJ) Questionnaire

Onset of Symptoms:

When did your jaw joint problems (i.e., pain, noises, headaches) begin? Age: _____ Year: _____

What started your jaw joint problems? ☐ injury ☐ disease ☐ unknown

Explain: _____

The following makes symptoms better:

_____

The following makes symptoms worse:

_____

Have you had previous TMJ surgery? ☐ Y ☐ N

How many operations? Right TMJ _____ Left TMJ _____

Has your jaw alignment or bite changed? ☐ Y ☐ N

How much has it changed? ☐ mild ☐ moderate ☐ severe

Current TMJ Symptoms:

What sounds do you hear in your joints when you open and close your mouth?

☐ Popping ☐ R ☐ L

☐ Clicking ☐ R ☐ L

Do you clench and/or grind your teeth at night? ☐ Y ☐ N

☐ clench ☐ day ☐ night ☐ mild ☐ moderate ☐ severe

☐ grind ☐ day ☐ night ☐ mild ☐ moderate ☐ severe

Do you wake up with facial pain? ☐ Y ☐ N

Has your bite changed? Do your teeth hit unevenly? ☐ Y ☐ N

Has the size of your mouth opening decreased? ☐ Y ☐ N

Have you even been stuck open and unable to close your mouth? ☐ Y ☐ N

If yes, how many times? ☐ 1 time ☐ 2 times ☐ 3 times ☐ > 4 times

Have you even been stuck closed and unable to open your mouth? ☐ Y ☐ N

If yes, how many times? ☐ 1 time ☐ 2 times ☐ 3 times ☐ > 4 times

Have you had to change your diet due to jaw discomfort? ☐ Y ☐ N

Has your chin moved backwards? ☐ Y ☐ N

Do you posture your lower jaw forward? ☐ Y ☐ N

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Do you get earaches? ☐ Y ☐ N

☐ left ☐ mild ☐ moderate ☐ severe ☐ occasionally ☐ frequently ☐ constantly

☐ right ☐ mild ☐ moderate ☐ severe ☐ occasionally ☐ frequently ☐ constantly

Do you get ringing in your ears? ☐ Y ☐ N

☐ left ☐ mild ☐ moderate ☐ severe ☐ occasionally ☐ frequently ☐ constantly

☐ right ☐ mild ☐ moderate ☐ severe ☐ occasionally ☐ frequently ☐ constantly

Do you get lightheadedness or dizziness? ☐ Y ☐ N

☐ mild ☐ moderate ☐ severe ☐ occasionally ☐ frequently ☐ constantly

Do you have pain in your temples? ☐ Y ☐ N

Are you in an emotional or stressful period in your life? ☐ Y ☐ N

Do you suffer from depression? ☐ Y ☐ N

Are you under treatment for depression? ☐ Y ☐ N

Have you had ulcers or stomach problems? ☐ Y ☐ N

Do you have headaches? (more detailed questions in next section) ☐ Y ☐ N

Headache History (if applicable)

Is the pain ☐ mild ☐ moderate ☐ severe

Are your headaches worse in the ☐ morning ☐ afternoon ☐ evening ☐ night ☐ no difference

How many headaches do you get in a day_____ week _____ month _____

Are the headaches ☐ occasional ☐ frequent ☐ constant

In which area(s) do your headaches occur?

☐ left forehead ☐ right forehead ☐ left temple ☐ right temple ☐ back of the head ☐ top of the head

☐ behind left eye ☐ behind right eye

Do you have pain elsewhere? ☐ Y ☐ N

☐ neck ☐ shoulder ☐ back pain

Is the pain ☐ mild ☐ moderate ☐ severe

What treatments have you tried to control your Head/Neck/TMJ Symptoms?

☐ cold/heat packs ☐ physical therapy ☐ diet change ☐ anti-inflammatory medication

☐ pain medication ☐ limited jaw movement ☐ injections-joint ☐ splint ☐ TMJ arthrocentesis

☐ TMJ surgery ☐ occlusal reconstruction ☐ braces ☐ physical therapy ☐ jaw surgery ☐ other

If other, please list: _____

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What type of clinicians have treated your head and neck symptoms?

☐ physical therapist ☐ TMJ specialist ☐ pain clinic ☐ oral surgeon ☐ orthodontist

☐ general dentist ☐ ENT ☐ neurologist

Circle the number that best describes your jaw situation:

TMJ Pain

(none) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)

Headaches

(none) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)

Average daily pain for head and neck area

(none) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)

Rate your jaw function for opening, side to side movement, and chewing

(normal function) 0 1 2 3 4 5 6 7 8 9 10 (no function)

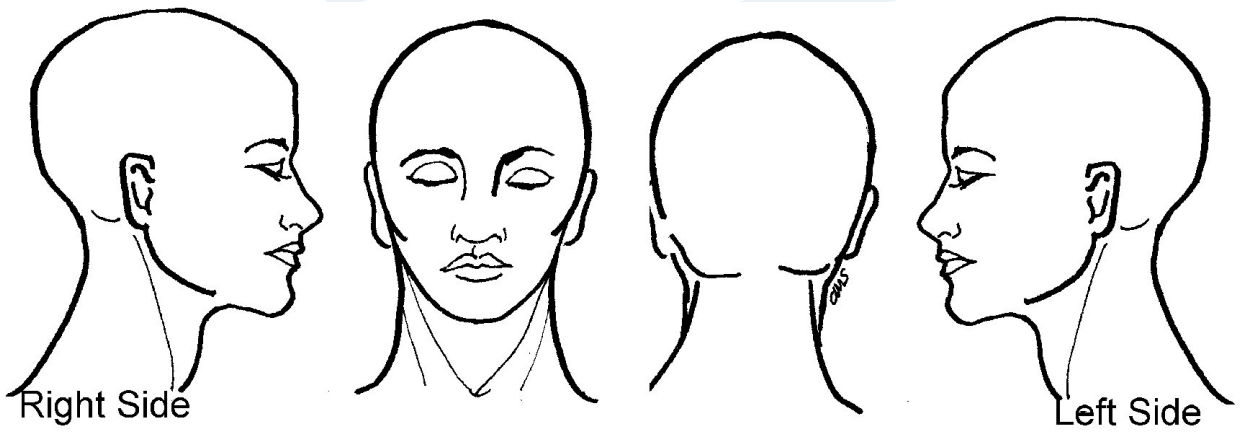
What can you chew?

(no restrictions) 0 1 2 3 4 5 6 7 8 9 10 (liquids only)

How much does your jaw function affect your ability to carry out normal life activities?

(none) 0 1 2 3 4 5 6 7 8 9 10 (disabled)

Please indicate your areas of pain on the diagram below:



Patient Name: _____ Date: _____