

TMJ Problem/ Headache History Questionnaire

Name: _____

Date: _____

Please describe your problem or concern: _____

Diagnostic Questions:

Can you chew bagels? _____

Can you chew gum? _____

Do you have more than one bite? _____

Have your teeth worn or changed in the last five years? _____

Do you sleep well? _____

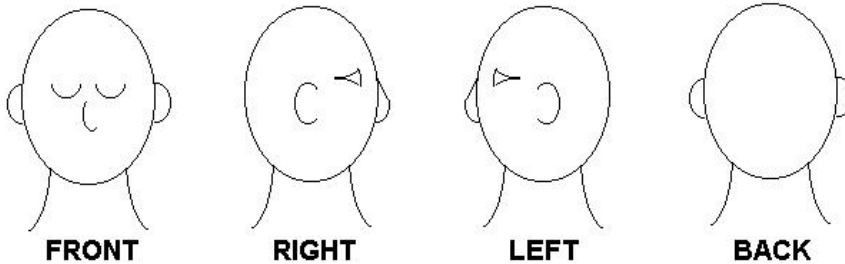
I. Which of the following do you have? Headaches Neck Pain Jaw Pain Ear Pain
 Facial Pain Other: _____

Which side hurts? Right Left Both

How would you describe the pain? Throbbing Aching Burning Stabbing

Shooting Other: _____

Shade in the area(s) where the pain is located:



II. How long have you had this pain? _____ Is this pain constant? Yes No

When is the pain worst? Morning Afternoon Evening Night

Please check the types of health care providers you have seen for your pain:

MD Neurologist ENT Internist Physical Therapist Chiropractor

Dentist Other: _____

Do you ever awaken with a headache? Yes No

Has an MD diagnosed you as having migraine or tension-type headaches? Yes No

III. Have you ever injured or sustained any form of trauma or whiplash to your:

Jaw Head Neck If yes, please describe: _____

IV. What makes the pain better? _____

What makes the pain worse? _____

What prescribed or over-the-counter medication(s) do you take or have previously taken for your pain?

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

- V. Does it hurt to chew? Yes No Does it hurt to open wide? Yes No
Which side of your jaw makes a popping noise? None Right Left
Which side of your jaw makes a clicking noise? None Right Left
Which side of your jaw makes other noises? None Right Left
Please describe: _____
When did you first notice joint noises? _____

- VI. Has your jaw ever locked? Yes No Did it lock open or closed? Open Closed
When did this first happen? _____
When did this last happen? _____
Has your jaw ever slipped out of place? Yes No Which side? Right Left

- VII. Have you noticed a change in your bite? Yes No
Did you notice a change at your front teeth? Yes No
Did you notice a change at your back teeth? Yes No
Has your profile changed? Yes No
Have you noticed any crookedness or asymmetry in your jaw? Yes No
When did you notice the asymmetry? _____

- VII. Are your teeth sore or sensitive? Yes No
Do you clench your teeth? Yes No Don't know
Do you grind your teeth? Yes No Don't know
If yes, do you do this during the day or night? Day Night Both

- IX. Do you have any problems with your ears? Yes No
Dizziness? Yes No Ringing? Yes No
Hearing? Yes No Other? _____

- X. Is it difficult or painful to swallow? Yes No
Have you noticed lumps in your face, throat or neck? Yes No

- XI. Have you had any prior treatment for TMJ problems? Yes No
Splint? Yes No Nightguard? Yes No
Bite adjustment? Yes No Orthodontics? Yes No
Surgery? Yes No If surgery, what type and which side? _____

Did any of these help? Please explain: _____

Describe your problems as you understand them: _____

Patient Signature

Date