

SCREENING QUESTIONNAIRE FOR TMJ PROBLEMS

NAME: _____ AGE _____ PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

REFERRED BY DR. _____

Describe your problem in your own words _____

use back if necessary

Do you have headaches _____ Neck Pain _____ Jaw Pain _____ Ear Pain _____ Face
Pain _____ Eye pain _____ Which side _____ Right _____ Left _____ Both _____

How long have you had these symptoms? _____ years _____ months _____ days

What brought these symptoms on?
(fall/accident/unknown) _____

Is the pain constant _____ aching _____ shooting _____ burning _____ stabbing _____
electrical _____ other _____ worse in AM _____ PM _____

Does it hurt to chew _____ Does it hurt to open wide _____

Does your jaw make a popping noise _____ clicking noise _____ grinding _____
right _____ left _____ both _____

Does your jaw ever lock open so you cannot close it? _____

Does your jaw get stuck momentarily or longer so that you cannot open
fully? _____

Does it hurt when you chew or use your jaws? _____

Does your pain continue when you are not using your jaws _____

Do you have pain, tingling, or numbness in your arms or fingers of your
hands? _____

Do you have painful sensations, tingling, or numbness in the head, neck or
shoulder region? _____

Is your sleep disturbed by pain of the head and neck region? _____

Are your daily activities or routine disturbed by pain of the head and neck
region? _____

Do you have problems with your ear _____ hearing _____ dizziness _____ ringing _____

Are your teeth sore or sensitive? _____

Are you taking medicine of any kind? _____

What kind? _____

Have you been treated for this problem by another doctor? _____

If so, who? _____