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TMD Questionnaire

Patient name:	
Address 1:	
Address 2:	
Phone:	

Symptoms:	Typically how many times per month?	Rate the intensity of your symptoms (0-10, 10 being severe pain)
Headaches		
Facial pain		
Neck pain		
Shoulder pain		
Joint noises		
Clenching/grinding		
Ear congestion		
Dizziness		
Fatigue		
Other symptom		

Describe other symptom:

Check all the boxes below that apply	RIGHT	LEFT	NONE
Pain in your temples			
Jaw popping			
Jaw clicking			
Ear pain			
Ear congestion			
Pain in front of the ear			
Pain behind the ear			
Hearing loss			
Recurrent ear infections			
Eye pain			
Pain/pressure behind the eyes			
Tingling in the hand or fingers			
Numbness in the hand or fingers			

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TMD Questionnaire

Do you have any concerns in the following areas? (answer yes or no)

	YES	NO
General appearance		
Ability to function		

	YES	NO
Overbite		
Smile		

Mark yes or no to these symptoms:

	YES	NO
Neck pain		
Limited movement of the neck		
Shoulder pain		
Shoulder stiffness		
Frequent biting of cheek		
Frequent snoring		
Teeth clenching		
Teeth grinding		
Dry mouth		
Burning sensation in tongue		
Pain/swelling in front of the neck		
Buzzing in the ears		
Tinnitus (ringing in the ears)		
Blurred vision		
Swelling in the neck		
Swollen glands		
Thyroid enlargement		
Tightness in the throat		
Chronic sinusitis		
Chronic sore throat		
Difficulty swallowing		
Heart palpitations		
Poor concentration		
Fatigue		
Weak muscles		
Sore muscles		
Agitation and/or anxiety		
Depression		
Sensation of lump in your throat		
Double vision		
Swelling or protrusion of eyes		
Change of facial appearance		

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TMD Questionnaire

When did your pain first occur? _____

Was there an incident that you believe to be the cause of your pain? _____

If so, describe: _____

Is there anything that makes your pain/discomfort worse? _____

Is there anything that makes your pain/discomfort better? _____

Is there anything else we should know in regards to your pain? _____

_____

History of treatment

Please list any treatment you have had or are currently receiving for this problem (including Practitioner's name, specialty, approximate date of treatment and treatment received).

_____

_____

_____

_____

_____

_____

_____

_____

_____

Head Pain History:

Which side are your headaches worse? Right: _____ Left: _____ None: _____

Where do your headaches spread to? Temples: _____ Back of Head: _____ Forehead: _____ None: _____

When having pain do you experience any of the following? (Mark all that apply)

Dizziness:		Throbbing:	
Sensitivity to light:		Fatigue:	
Burning:		Double Vision:	
Nausea:		Sensitivity to noise:	
Vomiting:		None:	

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc. to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I certify that this medical history information is complete and accurate.

Signature: _____ Date: _____