TMJ-TMD-MSD QUESTIONNAIRE

TMJ=Temporo-Mandibular Joint (Jaw joint) problem; TM Disorder & Muscle Skeletal Disorder=bad bite that may or may not include jaw joint problem.

If you know you have a TMJ-TMD-MSD problem, please print, fill out and bring this form to your first consultation.

1. Describe your problem _____
2. What do you think caused this problem? _____
3. Describe what you expect from treatment _____

_____

GENERAL HISTORY:

1. Are you presently under the care of a physician? ☐Yes ☐No Have you been in the past year? ☐Yes ☐No

   Condition treated _____

   Physician's name _____

   Treatment received _____

   Name of medication(s) you are currently taking _____

Poor Average Excellent

2. How would you describe your overall physical health? 0 1 2 3 4 5 6 7 8 9 10
3. How would you describe your dental health? 0 1 2 3 4 5 6 7 8 9 10

   Dentist's name _____ Date of last appointment _____

4. Have you had any major dental treatment in the last two years? ☐Yes ☐No
   If yes, please indicate which one(s) ☐Orthodontics ☐Periodontics ☐Oral Surgery
   ☐Restorative (filling, crown, bridge, partial or full denture (removable false teeth), implant) Circle each that applies.

   Date(s) of third molar (wisdom tooth) extraction(s) _____

1. **FACIAL INJURY/TRAUMA HISTORY -** Circle each that applies.

   Is there any childhood history of falls, accidents or injuries to the face or head? ☐Yes ☐No

   Describe _____

2. Is there any recent history of trauma to the head or face? ☐Yes ☐No
   Auto accident, sports injury, facial impact ☐Yes ☐No Circle each that applies.

   Describe _____

3. Is there any activity, which holds the head or jaw in an imbalanced position?
   Phone, swimming, instrument ☐Yes ☐No Circle each that applies.

   Describe _____

TMJ-TMD-MSD TREATMENT HISTORY

1. Have you ever been examined for a TMJ-TMD-MSD problem before? ☐Yes ☐No

   If yes, by whom? _____ When? _____

2. What was the nature of the problem? ☐Pain ☐Noise ☐Limitation of movement
3. What was the duration of the problem? ☐Months ☐Years
   Is this a new problem? ☐Yes ☐No
4. Is the problem ☐ Getting better ☐ Getting worse ☐ Staying the same?
5. Have you ever had physical therapy for TMJ-TMD-MSD? ☐Yes ☐No

   If yes, by whom? _____

6. Have you ever-received treatment for jaw problems? ☐Yes ☐No

   If yes, by whom? _____

   What was the treatment? ☐Bite Splint ☐Medication ☐Physical therapy ☐Occlusal Adjustment ☐Orthodontics

   ☐Counseling ☐Surgery ☐Other Describe _____

CURRENT PAIN LEVEL/MEDICATIONS/APPLIANCES

None Moderate Severe pain

1. Degree of current TMJ-TMD-MSD pain: 0 1 2 3 4 5 6 7 8 9 10
2. Frequency of TMJ-TMD-MSD pain: ☐Daily ☐Weekly ☐ Monthly ☐Semi-Annually
7. Is there a pattern related to pain occurrence? ☐Yes ☐No
   ☐Upon waking ☐Morning ☐Afternoon ☐Evening ☐After Eating
3. Are you taking medication for the TMJ-TMD-MSD problem? ☐Yes ☐No If yes, what type? _____

How long?_____ Who prescribed the medication?_____

4. Are the medications that you take effective? ☐Yes ☐No ☐Conditional
5. Are you aware of anything that makes your pain worse? ☐Yes ☐No

   If yes, describe _____

6. Does your jaw joint make noise? **RIGHT** ☐Click ☐Pop ☐Grind **LEFT** ☐Click ☐Pop ☐Grind

   Other_____

7. Does your jaw lock open? ☐Yes ☐No

   When did this first occur?_____How often?_____

8. Has your jaw ever locked closed or partly closed? ☐Yes ☐No

   When did this first occur?_____How often?_____

9. Have any dental appliances been prescribed? ☐Yes ☐No

   If yes, by whom?_____When?_____

   Describe _____

10. Are these appliances effective? ☐Yes ☐No
11. Is there any additional information that can help us in this area?_____

CURRENT STRESS FACTORS

☐Death of spouse	☐Death of a family member	☐Pending marriage
☐Major Illness or Injury	☐New person joins family	☐Pregnancy
☐Business adjustment	☐Marital separation	☐Marital reconciliation
☐Financial problems	☐Major health change in family	☐Taking on debt
☐Fired from work	☐Divorce	☐Career change

☐Other stress factors - Describe

HABIT HISTORY

1. Do you grind or clench your teeth together under stress? ☐Yes ☐No ☐Don't know
2. Do you grind or clench your teeth at night? ☐Yes ☐No ☐Don't know
3. Do you sleep with an unusual head position? ☐Yes ☐No ☐Don't know
4. Are you aware of any habits or activities that may aggravate this condition? ☐Yes ☐No ☐Don't know

   Describe _____

SYMPTOMS - check or circle what applies

HEAD, FACE PAIN
Head R L Face R L
Forehead R L Temple R L
Migraine headaches
Cluster headaches
Sinus headaches under the eyes
Headache back of head
Painful to touch hair scalp R L

EYE, EYE SOCKET
Pain above below behind
Bloodshot R L Bulging R L
Blurred vision R L
Pressure behind eye R L
Light sensitivity
Watering eye R L
Drooping eyelid R L

MOUTH, FACE, CHEEK, CHIN
Discomfort Limited opening
Inability to open smoothly

TEETH, GUMS
Clenching Grinding Day Night
Back teeth loose sore R L
Tooth pain R L Gums sore bleeding

JAW, JAW JOINT
Jaw joint clicking popping R L
Jaw joint grating sound R L
Jaw locking opened closed
Uncontrollable movement jaw tongue

EARS
Hissing Buzzing Ringing Roaring R L
Pain without infection R L
Clogged Stuffy Itchy R L
Balance problem Vertigo Dizziness
Diminished hearing R L

NECK, SHOULDER, BACK
Reduced mobility neck shoulder
Neck stiff pain
Shoulder stiff pain R L
Neck muscles tired sore
Back pain upper lower
Arm tingling numb pain R L
Finger tingling numb pain R L

THROAT
Swallowing difficulties
Tightness Sore
Voice fluctuation Laryngitis
Frequent coughing clearing
Feels like foreign object in throat
Tongue pain
Excess salivation
Pain in palate

OTHER SYMPTOMS - Describe

On the figures below, mark an "X" where you have pain. Circle the "X" where the pain is most severe.