TMJ Evaluation History

Instructions: This questionnaire will help us to understand your problem and should be completed before your first appointment. We know that this form is long and will take time, but please read and answer every question carefully so that we can make the correct diagnosis. Try to answer the questions by yourself, without any assistance from anyone else, if possible.

Name: _____Date: _____

Who referred you? _____

On the lines below, list the name of health care practitioners you have consulted for your main problem. Briefly describe their diagnosis, treatment, and results.

Dr._____Specialty: _____

Address: _____Telephone: _____

Diagnosis and treatment: _____

_____

Dr._____Specialty: _____

Address: _____Telephone: _____

Diagnosis and treatment: _____

_____

Dr._____Specialty: _____

Address: _____Telephone: _____

Diagnosis and treatment: _____

_____

Dr._____Specialty: _____

Address: _____Telephone: _____

Diagnosis and treatment: _____

_____

If additional space is required, please use an additional sheet of paper.

Is there any legal action pending as a result of your problem? □ yes □ no

If yes, please give your attorney's name and address:

Name: _____

Address: _____Telephone: _____

Chief complaints: Write the problems that bothers you most FIRST and the next most bothersome problem SECOND and so on. Please include any headache complaints.

1._____

2._____

3._____

4._____

5._____

Symptoms: If you have any of the following symptoms, please indicate right or left.

	R	L
Frequent headaches	□	□
Facial pain	□	□
Pain or discomfort on chewing	□	□
Pain or soreness in jaw joints	□	□
Noises in jaw joints	□	□
Can't open mouth wide	□	□
Locking of jaw open	□	□
Feeling that bite is off	□	□
Clenching or grinding of teeth	□	□
Neckaches	□	□
Shoulder pain	□	□
Tension or stiffness in neck	□	□
Back pain or aches	□	□

	R	L
Difficulty in turning head to	□	□
Ear pain	□	□
Ringing, buzzing, hissing in ears	□	□
Hearing loss or fullness in ears	□	□
Dizziness (postural imbalance)	□	□
Pain in, around or behind eyes	□	□
Blurred vision (not corrected by glasses)	□	□
Difficulty in swallowing	□	□
Painful or burning tongue	□	□
Teeth or gum pain	□	□

Additional symptoms: _____

_____

_____

_____

History: Please refer back to your main problem(s) and answer the following questions:

A. When did you first notice the symptoms? _____

B. What caused the onset of this condition (you may check more than one):

- □ Auto accident
- □ Accident at home
- □ Accident at work
- □ Whiplash injury
- □ Following surgery
- □ Following illness
- □ Medical/dental treatment
- □ Stressful situation
- □ Pain "just began"
- □ Other (specify)

_____

C. How fast did the condition arise? □ Over months □ Over weeks □ Over days □ In one day

D. How has the condition changed since it began? □ Increased □ Decreased □ Stayed the same

E. Since your condition began, which of the following practitioners have you consulted for treatment? Indicate year and number of visits.

	Year	Major Relief	Some Relief	No Change	Felt Worse
Acupuncturist	_____	□	□	□	□
Allergist	_____	□	□	□	□
Chiropractor	_____	□	□	□	□
Dentist	_____	□	□	□	□
Ear, nose, throat	_____	□	□	□	□
Endocrinologist	_____	□	□	□	□
General practitioners	_____	□	□	□	□
Gynecologist	_____	□	□	□	□
Internist	_____	□	□	□	□
Neurologist	_____	□	□	□	□
Neurosurgeon	_____	□	□	□	□
Nutritionist	_____	□	□	□	□
Opthamologist	_____	□	□	□	□
Osteopath	_____	□	□	□	□
Physical therapist	_____	□	□	□	□
Psychiatrist	_____	□	□	□	□
Psychologist	_____	□	□	□	□
Surgeon (general)	_____	□	□	□	□
Other _____		□	□	□	□

What makes your symptoms WORSE?

1._____

2._____

3._____

4._____

What causes your symptoms to DECREASE?

1._____

2._____

3._____

4._____

How often do your symptoms occur?

□ Continuously □ Several times a day □ Once a day

□ Several times a week □ Several times a month □ Once a month

□ Less than once a month

When your symptoms occur, how long do they last?

□ Continuously □ For weeks □ For days

□ For hours □ For minutes □ For seconds

□ Variable: _____

When are your symptoms worse?

□ Upon rising □ Morning □ Afternoon □ Evening □ During sleep

Which word group best describes the pattern of your pain?

□ Continuous, steady, constant

□ Rhythmic, periodic, intermittent

□ Brief, momentary, transient

Has anyone in your family had a similar condition?

□ No □ Yes If yes, please explain: _____

_____

_____

_____

Effect of pain on daily living:

How would you rate your facial/head pain at the present time using a 0 to 10 scale where 0 is “no pain” and 10 is “pain as bad as could be.” Circle the most accurate number.

No Pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

In the past 6 months, on the average, how intense was your pain?

No Pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

Please indicate how much facial/head pain has changed your ability to take part in recreational, social, and family activities where 0 is “no change” and 10 is “extreme change.”

No Change										Extreme change
0	1	2	3	4	5	6	7	8	9	10

Pain experience:
Complete this section only if PAIN is one of your chief complaints. Some of the groups below contain words that describe your PRESENT pain. Circle only ONE word in each group which best describes how it feels. If a group does not apply to you, leave it out.

Flickering	Jumping	Pricking	Sharp
Quivering	Flashing	Boring	Cutting
Pulsing	Shooting	Drilling	Lacerating
Throbbing		Stabbing	
Beating		Lancinating	
Pounding			

Pinching	Tugging	Hot	Tingling
Pressing	Pulling	Burning	Itchy
Gnawing	Wrenching	Scalding	Smarting
Cramping		Searing	Stinging
Crushing			

Dull	Tender	Tiring	Sickening
Sore	Taut	Exhausting	Suffocating
Hurting	Rasping		
Aching	Splitting		
Heavy			

Fearful	Punishing	Wretched	Annoying
Frightful	Grueling	Blinding	Troublesome
Terrifying	Cruel		Miserable
	Vicious		Intense
	Killing		Unbearable

Spreading	Tight	Cool	Nagging
Radiating	Numb	Cold	Nauseating
Penetrating	Drawing	Freezing	Agonizing
Piercing	Squeezing		Dreadful
	Tearing		Torturing

Past medical history:
Please list any operations and hospitalizations you have had and the dates they occurred.
1._____

2._____

3._____

4._____

Please list any trauma or accidents you have had and dates.
1._____

2._____

3._____

4._____

Please list any medication, food, inhaled substance, or environmental factor that you may be allergic to?
_____

_____

_____

Do you…

	Yes	No
Have a stressful situation at work?	□	□
Have a stressful situation at home?	□	□
Have a decreased desire for social activities?	□	□
Have little interest in doing things?	□	□
Feel lonely even with people?	□	□
Feel hopeless about the future?	□	□

Have a decreased appetite?	□	□
Have a loss of sexual interest or pleasure?	□	□
Feel low in energy or slowed down?	□	□
Feel easily annoyed or irritated?	□	□
Consider yourself to be a perfectionist?	□	□
See or have ever seen a psychiatrist, psychologist, or social worker?	□	□

If yes, please explain _____

Sleeping habits:

Do you…

	Yes	No
Sleep well at night	□	□
Have trouble falling asleep	□	□
Take medication/alcohol to fall asleep?	□	□
Wake up during the night?	□	□
Snore while sleeping?	□	□
Gasp for air in your sleep?	□	□
Mouth breathe while sleeping?	□	□
Clench your teeth at night?	□	□
Thrash your legs in your sleep?	□	□
Have a headache upon rising?	□	□
Feel exhausted upon rising?	□	□
Wake up too early in the morning?	□	□
Have stiff muscles in the morning?	□	□
Feel rested upon rising?	□	□
Have difficulty staying awake during the day?	□	□
Feel tired during the day?	□	□
Read or watch TV in bed?	□	□
Use two pillows?	□	□
Sleep on your stomach?	□	□

Please note how much your "chief complaint" disturbs your sleep by circling the corresponding number:

Does Not prevent										Completely Prevents
0	1	2	3	4	5	6	7	8	9	10

Lifestyle:
Please answer each question with one mark (X) on each line. What is your usual level?

Activity	Lie in bed All day		Rest half the day	Rest few times a day	Active all day
Exercise	None	Very Little	Work around house	Moderate	Regular
Social activity	None		Very Little	Moderate	Very Active
Eating	Poor appetite		Mostly snack	Eat well	Over eat
Caffeine beverages	None	1-2 Daily	3-4 Daily	Over 6 Daily	Not aware
Take vitamins	None		Occasionally	Daily	Megadoses
Alcoholic beverages	None	On Occasion	1-2 Daily	3-4 Daily	More than 4 Daily
Smoke tobacco	None		Occasionally	Less than 1 Pack daily	More than 1 Pack daily
Recreational drugs	None		Occasionally	Daily	More than Once daily

What do you hope to gain from treatment? _____

_____