

TMJ QUESTIONNAIRE

Date _____ D.O.B. _____

Indicating whether or not you currently have, or conditions or symptoms.

- | | | | |
|--|--|---|--|
| 1. Have you had Orthodontic treatment? | <input type="checkbox"/> yes <input type="checkbox"/> no | 15. Do you have neck aches? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 2. Wisdom teeth removed? | <input type="checkbox"/> yes <input type="checkbox"/> no | 16. Sinus problems? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 3. Do you chew gum regularly? | <input type="checkbox"/> yes <input type="checkbox"/> no | 17. Do you snore? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 3. Treated for a "bad bite"? | <input type="checkbox"/> yes <input type="checkbox"/> no | 18. Do you have sleep apnea? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 4. TMJ (jaw joint) treatment? | <input type="checkbox"/> yes <input type="checkbox"/> no | 19. Earaches or ear pain? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 5. Sore or sensitive teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no | 20. Grating noises in ears
(like grating sand particles) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 6. Do you have chronic headaches? | <input type="checkbox"/> yes <input type="checkbox"/> no | 21. Are your teeth badly worn? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 7. Do you ever have migraines? | <input type="checkbox"/> yes <input type="checkbox"/> no | 22. Pain in, around, or behind eyes? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 8. Do you have tension headaches? | <input type="checkbox"/> yes <input type="checkbox"/> no | 23. Are you under a lot of stress? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 9. Headaches in back of the head? | <input type="checkbox"/> yes <input type="checkbox"/> no | 24. Whiplash or neck injury? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 10. Do you have ear pain? | <input type="checkbox"/> yes <input type="checkbox"/> no | | |
| 11. Does it hurt to open wide? | <input type="checkbox"/> yes <input type="checkbox"/> no | | |
| 12. Do you have difficulty chewing? | <input type="checkbox"/> yes <input type="checkbox"/> no | | |
| 13. Does your jaw ache when you chew? | <input type="checkbox"/> yes <input type="checkbox"/> no | | |
| 14. Pain in teeth on awakening? | <input type="checkbox"/> yes <input type="checkbox"/> no | | |

Jaw (TMJ) symptoms

- | | |
|---|--|
| 1. Have you ever been treated for jaw joint problems? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 2. Do you grind your teeth at night? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 3. Are you aware of clenching your teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 4. Are there times when you can't open your mouth widely? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 5. Does it hurt to open your mouth widely? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 6. Has your jaw ever locked and made you unable to open/close your mouth? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 7. Do your jaws make a clicking or popping sound when you chew? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 8. Is it painful to yawn | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 9. Do you have pain in your neck/shoulders? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 10. Have you ever had a severe blow to the head? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 11. Have you ever had a night guard/ splint? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 12. Do you currently wear a night guard/splint? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 13. Pain in Right jaw joint? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 14. Pain in left jaw joint? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 15. Do you hear sound in your jaw joint? | <input type="checkbox"/> yes <input type="checkbox"/> no |
| 16. Do you have generalized facial pain? | <input type="checkbox"/> yes <input type="checkbox"/> no |
- If yes, which side? right left

On a scale from 1 - 10 please rate your current level of pain of your jaw joints

- | | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| low | | | | moderate | | | | high | |