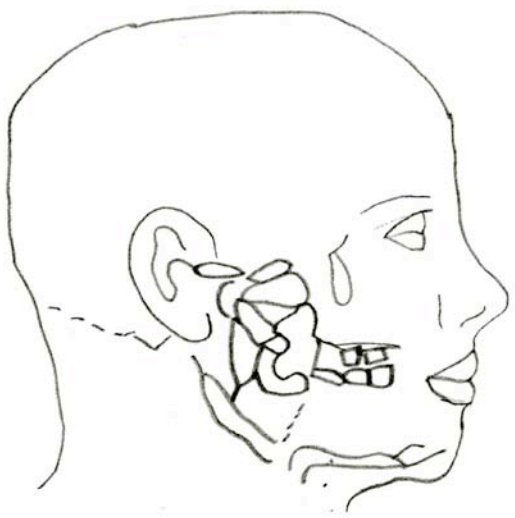
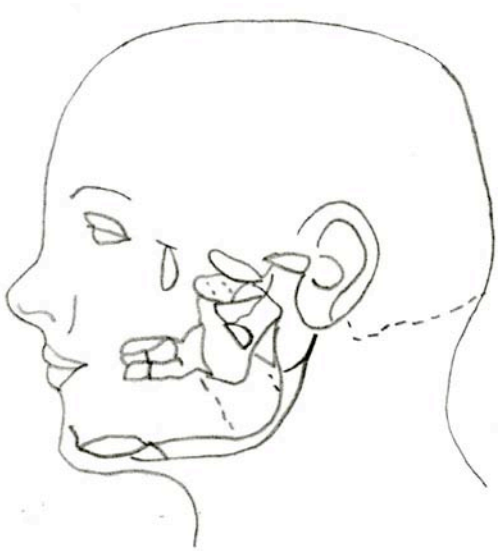
Date

TMJ HISTORY

1. **Name** **Age**
2. **Referred by**
3. **Describe your problem:**
4. **Which side hurts? Right Left Both**
5. **For how long?**
6. **Is the pain constant or intermittent?**
7. **Is the pain worse in the morning, afternoon, or evening?**
8. **Does it hurt to move your jaw?**
9. **On the figure below, please outline where your pain is.**





10. **Does your jaw make noise?**

    Clicking **Grinding** **Other**

    When does it do this?

    For how long?

11. Has your jaw ever locked open or closed?

When? **For how long?**

12. Do you have any of the following problems?

Headaches	Yes	No
Neck aches	Yes	No
Shoulder pain	Yes	No
Ear pain	Yes	No
Ringing in the ears	Yes	No
Dizziness	Yes	No
Change in hearing	Yes	No

13. Do you grind or clench your teeth? At night or During the day

14. Do you have sore or sensitive teeth? Yes No

15. Do you have trouble getting to sleep? Yes No

16. Do you consider yourself to be under a lot of stress? Yes No

17. Are you nervous or anxious about anything? Yes No

18. Have you ever had arthritis? Yes No

19. Have you ever had a nervous stomach, ulcers, or skin disease? Yes No Please list:

20. Does your pain keep you from doing anything? Yes No Describe:

21. Can you remember any injury to your jaw? Yes No Describe:

22. Do you take any medications for relaxation? Yes No Please list:

23. Have you had any treatments for your problem? If YES, what kind:

Bite splint	Yes	No	
Medication	Yes	No	List:
Physical therapy	Yes	No	
Counseling	Yes	No	
Occlusal adjustment	Yes	No	
Orthodontics	Yes	No	
Surgery	Yes	No	
Other List:			