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TMJ Therapy and Orofacial Pain

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1. *Name:* ____

2. *Referred by Dr.* ____

3. *Do you have headaches?* ______ *Neck pain?* ______ *Jaw pain?* ______
   Ear Pain? ______ *Face pain?* ______ *Eye Pain?* ______ *Other?* ______

4. *Is your problem caused by or related to an accident or injury?* __________________

5. *How long have you had these symptoms?* ______ *years* ______ *months* _____ *days*

6. *Is the pain continuous?* ______ *aching?*______ *shooting?* ______ *burning?* ______
   stabbing? _____ *electrical?* ______ *other?* ______ *Worse in the morning?* ______
   Worse in the afternoon? ______ *Worse in the evening?* ______

7. *Does it hurt to chew?* ______ *Open wide?* ______

8. *Does your jaw make a popping noise?* ______ *clicking?* ______ *grinding?* ______
   other? ______

9. *Has your jaw ever "locked" or slipped out of place?* ______ *Describe:* ___________
   ____

10. *Do you clench or grind your teeth?* ______ *During the day?* ______ *At night?* _____

11. *Do you have problems with your ears?* ______ *hearing?* ______ *dizziness?* ______
    other? ______

12. *Is it difficult to swallow?* ______ *painful?* ______

13. *Are your teeth sore or sensitive?* ______

14. *Have you ever been treated for a TMJ problem in the past?* ______ *when?* ______
    Treatment ________________________________

15. *Describe your problem in your own words (use back if necessary).* ______________
    ____
    ____

____

Signature *Date*